# New Legislator Enrollment Form

**Use this form to elect State of Montana Benefit Plan (State Plan) coverage.**

This **form must be postmarked or returned within 31 days of your legislative appointment** to the Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130. Your benefits will be effective retroactive to your legislative appointment date.

**If you do not submit your enrollment form within 31 days of your legislative appointment, you will not be enrolled in the State Plan, and all of your benefit options will be waived.**

You may also complete your New Legislator Enrollment online at doa.mt.gov/HCBD.

- If accessing on the State of Montana network, navigate to the "On State Network Benefit Enrollment System Access" button to automatically enter the system. You will not be required to register.
- If accessing outside of the State of Montana network, navigate to the "Off State Network Benefit Enrollment System Access" button then login using the prompts provided.
    - First time users will need to register with a username and password then answer a few security questions. The case-sensitive company key is stateofmontana.

The Health Care & Benefits (HCBD) website, doa.mt.gov/HCBD, includes important benefit information to help you understand State Plan rates, coverage, and benefit options.

## Personal Information

Last Name _____ First Name _____ MI ___

Mailing Address_____ City _____ State _____ Zip _____

Legislator ID# _____ Last Four of SSN _____ Date of Birth _____

Phone Number _____ Email _____

Date of Legislative Appointment _____

## Waiver of Coverage

Legislators who waive State Plan coverage may have additional option available to them. To waive your coverage, you must fill out the Legislator Opt Out/Waiver Form. Request this for by contacting HCBD at (800) 287-8266, TTY (406) 444-1421, or email BenefitsQuestions@mt.gov.

## Coverage Election

Enter the information for yourself, any spouse or domestic partner, and/or dependent children you would like to add to your Medical and/or Dental coverage.

- Legislators must enroll in Medical to enroll in any other State Plan benefits. Medical includes Medical, Prescription Drug, and Basic Vision.
- Refer to the Wrap Plan Document (WPD), doa.mt.gov/HCBD/resources/publications, for an outline of the State Plan eligibility requirements.

**Table 1: Legislator Elections for Medical and Dental**

| Full Name | Date of Birth | Relationship | SSN | Medical (Y or N) | Dental (Y or N) |
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**Verification of Eligibility -** If you are adding a spouse or domestic partner and/or dependent children during Open Enrollment, you are required to submit the verification of eligibility documentation. Dependent verification documentation must be attached to this form upon submission for the dependent to be enrolled.

- Dependent Children
  - A copy of the child's birth certificate, adoption orders, pre-adoption orders; or
  - A copy of a court-ordered parenting plan, custody agreement or guardianship order.
- Domestic Partner
  - Declaration of Domestic Partner Relationship and Affidavit of Shared Residence forms which includes two forms of proof of address for each partner matching the address on the Affidavit of Shared Residence form (forms available on the HCBD website at doa.mt.gov/HCBD/resources/forms); and
  - A copy of mutually granted powers of attorney or health care powers of attorney; or
  - A copy of mutual designations of primary beneficiary in wills, life insurance policies, or retirement plans.
- Grandchildren
  - A copy of the grandchild's adoption orders or pre-adoption papers; or
  - A copy of a court-ordered custody agreement or guardianship order.
- Spouse
  - A copy of the certified marriage certificate; or
  - A copy of the front page of the most recent tax return showing the tax filing status as "married", any financial information may be blacked out; or
  - A copy of the recorded and notarized Affidavit of Common Law Marriage (available on the HCBD website at doa.mt.gov/HCBD/resources/forms).
- Stepchildren and Domestic Partner Children
  - Required documentation listed above for Spouse or Domestic Partner, if individual is not enrolled; and
  - A copy of the stepchild's or domestic partner child's birth certificate, adoption orders, pre-adoption orders; or
  - A copy of a court-ordered parenting plan, custody agreement, or guardianship order.

## Joint Core Election

Applies only to employees, legislators, and their spouses or domestic partners who are both State employees, eligible for State Plan coverage, have eligible children, and wish to enroll themselves and their children on State Plan coverage. Your spouse or domestic partner must also submit Mid-Year Change Form to elect Joint Core status.

- ❑ Elect Joint Core – Spouse/Domestic Partner Name & Last Four of SSN _____

## Vision Hardware Coverage

You and/or your dependents must be enrolled in the Medical Plan to be eligible for the Vision Hardware Plan. If you check yes, **all** dependents enrolled on your Medical Plan will have Vision Hardware coverage.

- ❑ YES, I want to enroll
- ❑ NO, I do not want to enroll

## Tobacco Surcharge

A Tobacco Surcharge applies if you or your covered spouse or domestic partner is a nicotine user. Read the definition of Nicotine, Nicotine Free, and Nicotine User, then answer the questions based upon you and/or your covered spouse or domestic partner's use of nicotine.

**Nicotine**

- Nicotine is an addictive stimulant proven to have negative health effects. Nicotine is found in a variety of products such as cigarettes, cigars, chewing tobacco, vaping or electronic products, oral products, and more.

**Nicotine Free**

- You are nicotine free if you have never used nicotine, have quit using nicotine, use only FDA-approved Nicotine Replacement Therapy (NRT), or infrequently use nicotine (less than 4 times per month).
- You are nicotine free if you are currently using nicotine but have completed an eligible alternative (nicotine cessation program or a nicotine counseling session with a medical provider) during the past 12 months.
- Answer No – I am not currently a nicotine user.

**Nicotine User**

- You are a nicotine user if you are currently using nicotine and have not completed an eligible alternative (nicotine cessation program or a nicotine counseling session with a medical provider) during the past 12 months. If you or your covered spouse or domestic partner fits this definition, the surcharge will apply and $60 per month will be charged for the retiree who uses nicotine and/or $60 per month if the retiree's covered spouse or domestic partner uses nicotine.
- Answer Yes – I am currently a nicotine user.

Based upon the definitions, are **you** currently a nicotine user?

- ☐ No, I am not currently a nicotine user. Monthly $60 Tobacco Surcharge will not apply.
- ☐ Yes, I am currently a nicotine user. Monthly $60 Tobacco Surcharge will apply.

Based upon the definitions, is **your covered spouse or domestic partner** currently a nicotine user?

- ☐ No, my covered spouse or domestic partner is not currently a nicotine user. Monthly $60 Tobacco Surcharge will not apply.
- ☐ Yes, my covered spouse or domestic partner is currently a nicotine user. Monthly $60 Tobacco Surcharge will apply.
- ☐ NA – I do not have a covered spouse or domestic partner.

## Life Insurance

### Table 2: Legislator Elections for Life Insurance

| Coverage | Yes | No | Amount Requested |
|---|---|---|---|
| **Basic Life Insurance (Required)** | X | | $14,000 |
| * **Legislator Supplemental Life Insurance** – $5,000 increments up to a maximum coverage amount of $1,000,000. Minimum election must be $25,000. | | | |
| **AD & D with Dependents** - $25,000 increments up to a maximum coverage amount of $1,000,000. | | | |
| **AD & D without Dependents** - $25,000 increments up to a maximum coverage amount of $1,000,000. | | | |
| ** **Dependent Life Insurance**<br>Option A - $2,000 spouse, $1,000 per child<br>Option B - $4,000 spouse, $2,000 per child | **Circle Coverage Option**<br>☐ **or** ☐ | | Not Applicable |
| ***Spouse Supplemental Life Insurance** - $5,000 increments up to the amount you elected for Legislator Supplemental Life, up to a maximum of $500,000. | | | |

***Evidence of Insurability (EOI)** – If you are making a first-time election or electing an increase of more than $10,000 to Legislator Supplemental Life or electing more than $10,000 in Spouse Supplemental Life, you must complete an EOI application. You can access the application at doa.mt.gov/HCBC/life-accident or you can request the application by calling HCBD at (800) 287-8266. Be aware, you will not receive a reminder regarding the requirement to complete the EOI. Failure to complete EOI will result in NO life insurance enrollment or increases, beyond the $10,000 allowed for Legislator Supplemental Life if already enrolled or any amount of Spouse Supplemental Life over $10,000.

**Dependent Life is only available during 31-day initial enrollment period or within the first 60 day of marriage or 91 days of having your first child.

## Beneficiary Designation

This designation will apply to the life insurance elections made above.

- Benefits are payable to contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiarieswill share equally, unless you provide for unequal shares.
- In the event you are divorced, unless set forth by the express terms of a governing instrument, court order, or contract relating to the division of the martial estate between divorced individuals, a life insurance beneficiary designation to an ex-spouse will be revoked.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust mut be identified in the Beneficiary designation. For example, Dorothy Q. Smith, Trustee under the trust agreement dated _____.
- A power of attorney must grant specific authority, by the terms of the document or applicable law to make or change a beneficiary designation. If you have questions, consult your legal advisor.
- Dependent Insurance and Supplemental Life Insurance on your spouse or domestic partner, if any, is payable to you, or as provided under the State Plan's coverage under the policy.
- If you complete the % of Benefit boxes, the amounts should add up to 100% for each class (primary or contingent).
- If you need more space, attach additional page with the information below included.

**Table 3: Beneficiary Designation**

| Primary or Contingent | Full Name | Address | Date of Birth | Relationship | % of Benefit |
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## Signature

I request the elections indicated and authorize the associated payroll deduction. In the event I am unable to print and sign this form, or add my electronic signature, I will type my name in the signature line below and return to HCBD via email from my State email account. HCBD will use the State email account as validation for signature and will maintain such record with this form.

I understand if I am adding a spouse to my Plan, deductions for my spouse will default to the pre-tax plan. I understand if I am adding a domestic partner, deductions for his/her benefits will default to after-tax deductions. I understand it is my responsibility to make any changes to my tax status by completing a Declaration of Tax Status form and sending the form back to BenefitsQuestions@mt.gov. I understand failure to return the Declaration of Tax Status form will result in my spouse or domestic partner being defaulted to the tax status indicated above.

By signing below, I certify that the above information is correct, and my coverage elections are considered an irrevocable agreement for this plan year and I understand I can only enroll dependents in my State Plan during my initial enrollment or by qualifying for a Special Enrollment Period as defined in the Warp Plan Document.

Signature:_____Date:_____

## State of Montana Non-Discrimination Statement

State of Montana complies with applicable federal and state non-discrimination laws and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or related medical conditions, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, national origin, ancestry, age, disability, military service, veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively, including qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English, including qualified interpreters and information written in other languages. If you need these services, contact HCBD at (800) 287-8266. If you believe that State of Montana has failed to provide these services or has discriminated against you in another way, you can file a grievance. If you need help filing a grievance, the State Diversity Coordinator is available to help you. You can file a grievance in person or by mail, fax, or email to: State Diversity Program Coordinator, Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3871 Email: SABHRSHR@mt.gov.

## Language Assistance - General Taglines

State of Montana is required by federal law to provide the following information.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-866-270-3877 (TTY:711)。

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-866-270-3877 (TTY:711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-270-3877 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-270-3877 (ATS : 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-270-3877 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-270-3877 (TTY: 711)번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-866-270-3877 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-270-3877 (TTY: 711).