

CHOICES 2009/2010 COBRA Annual Open Enrollment Form

Montana University System's Flexible Benefits Program

**Total
Monthly
Costs**

Medical					
Choose one plan and indicate the number of covered adults and/or children:	<input type="checkbox"/> Employee or Spouse or Individual Child(ren) (each) Monthly costs	<input type="checkbox"/> Employee + Spouse Monthly Cost ¹	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family	
<input type="checkbox"/> Traditional Plan A	\$579.00 Number _____	\$686.00	\$675.00	\$794.00	
<input type="checkbox"/> Traditional Plan B	\$667.00 Number _____	\$791.00	\$778.00	\$914.00	
<input type="checkbox"/> New West Managed Care Plan:	\$527.00 Number _____	\$624.00	\$615.00	\$722.00	
<input type="checkbox"/> Peak- Managed Care Plan:	\$533.00 Number _____	\$631.00	\$621.00	\$729.00	
<input type="checkbox"/> Blue Cross Blue Shield - Blue Choice Managed Care Plan:	\$493.00 Number _____	\$583.00	\$574.00	\$674.00	
<input type="checkbox"/> Allegiance Managed Care Plan:	\$510.00 Number _____	\$604.00	\$595.00	\$698.00	

Enter your monthly cost here \$ _____ (A)

Dental					
Choose one plan and one coverage level:	<input type="checkbox"/> Employee or Spouse or Child (each)	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family	
<input type="checkbox"/> Premium Plan	\$44.00 Number _____	\$83.00	\$83.00	\$117.00	
<input type="checkbox"/> Basic Plan	\$17.00 Number _____	\$33.00	\$33.00	\$47.00	

Enter your monthly cost here \$ _____ (B)

Vision		
<input type="checkbox"/> Yes	<input type="checkbox"/> Employee or Spouse or Child (each) ----- \$7.80	\$ _____ (C)
<input type="checkbox"/> No	<input type="checkbox"/> Employee + Spouse ----- \$14.71	
	<input type="checkbox"/> Employee + Child(ren) ----- \$15.48	
	<input type="checkbox"/> Employee + Family ----- \$22.71	

Optional Reimbursement Accounts	Write in the monthly amount you wish to allocate to your Expense Accounts. If you don't wish to participate or were not participating prior to qualifying for COBRA write in \$0	
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Health Care Reimbursement Account (Minimum \$10; Maximum \$500.00) Enter your cost here \$ _____ (D)

Costs

Your Total Monthly Costs [Add up all your costs from right-hand column of this form (A) through (D)] \$ _____

*The cost to continue COBRA coverage is up to 102% of the cost of coverage for similarly situated active employees and/or family members.
The actual cost is not the same as the amounts used for CHOICES enrollment purposes.*

Check reason you are completing this form:

Administrative Use Only

¹ Children placed individually on the plan each pay the adult rate.

- New COBRA Enrollment
- Annual COBRA Re-enrollment
- Other _____

Campus Location: _____

Effective Date: _____

Insurance Class: _____

MUS Employee
Name: _____

SSN: _____

Personal

COBRA Applicant Name: _____ Birth Date: ____/____/____

Address: _____ SSN: _____

City: _____ State: _____ ZIP: _____ Sex: Male Female

Telephone Number: _____ Marital Status: Married Single

If your spouse is still an eligible faculty or staff member, please provide his/her name, campus, and Social Security Number.

Spouse's Name: _____ SSN: _____

Campus: _____

List All Eligible Family Members Enrolled for Medical, Dental, or Vision Coverage

Name (Last, First, MI):	Birth Date (mm/dd/yyyy)	Enrolled in:			SSN	Disabled	Check for Children Over Age 19:
		Medical	Dental	Vision			
Spouse	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Please attach list of additional family members.

I understand that any continued coverage elected on this form will terminate immediately upon the occurrence of one of the following events, regardless of whether premiums have been paid for coverage after such event: failure to pay the required premium on time; becoming covered under another group health plan not maintained by the Montana University Systems provided the individual does not have a preexisting condition which the new plan does not cover due to a plan exclusion or limitation; becoming entitled to Medicare; or termination by the Montana University System of all group health plans for all employees. I also understand that if extended coverage is provided due to Social Security disability, continued coverage will cease if the disabled individual is determined to have recovered. In such cases I will be entitled to a refund of any overpayment of premiums. I authorize the claims administrator or insurance company to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I declare that the information furnished on this form is true, correct and complete to the best of my knowledge. This form supersedes all previous forms I have submitted.

Employee's Signature: _____

Date: _____