

**Sample MUST Enrollment Form**  
See the following pages for instructions and tips.



ENROLLMENT FORM for 2006/2007

Information in Sections 1-5 REQUIRED

<b>COMPLETE ALL SECTIONS BELOW FOR NEW ENROLLMENTS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE REVIEW IMPORTANT NOTICES ON THE BACK.</b>		<b>1</b>	Group No: <i>670-1234</i>	School District: <i>SAMPLE SCHOOL</i>	<b>2</b>
Employee Name (FIRST) (INITIAL) (LAST) <i>JOE L. TEACHER</i>		Application for: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Participant & Spouse <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family			
Address <i>P.O. Box 1234</i>		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Married <input type="checkbox"/> Separated			
City State Zip <i>Somewhere MT 59104</i>		First day at work <i>08/27/2001</i>			
Telephone No. <i>444-1245</i>		Effective Date as determined by contract or district policy: <input type="checkbox"/> First Day At Work <i>08/27/2001</i> <input type="checkbox"/> First of the month following first day at work <i>09/01/2001</i> <input checked="" type="checkbox"/> Other <i>07/01/2005</i>			
If you are waiving health benefits stop here. Complete waiver form on the back.		Type of Benefits: <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental (E) <input checked="" type="checkbox"/> Vision (E) (Circle E for Employee Only)			
Social Security # <i>123-45-6789</i>	Sex <i>M</i>	Birth Date <i>7/20/72</i>	Plan & Deductible Level: <input type="checkbox"/> CM200 <input type="checkbox"/> CM500 <input type="checkbox"/> CM750 <input type="checkbox"/> CM1000 <input type="checkbox"/> CM2000 <input type="checkbox"/> CM5000 <input type="checkbox"/> RM200 <input checked="" type="checkbox"/> RM500 <input type="checkbox"/> RM1000 <input type="checkbox"/> RM 1500 <input type="checkbox"/> RM2000 <input type="checkbox"/> BP2000 <input type="checkbox"/> HSA 1200 Copay: <input type="checkbox"/> 70/30 <input checked="" type="checkbox"/> 80/20		
Occupation/Job Title <i>Educator</i>	Hrs Worked Wkly <i>40+</i>		Plan Status: <input checked="" type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> COBRA <input type="checkbox"/> Leave Of Absence <input type="checkbox"/> Disabled Qualifying Date: ___/___/___		
FOR MUST USE ONLY: Date Entered ___/___/___		NOTES: _____			

<b>DEPENDENT FAMILY MEMBERS</b> (Please Print) – Dependent Information: Complete for each of your dependents and indicate if they are to be covered. If not, you must complete the Waiver form on the back. You may attach a separate sheet of paper if you need more room for dependent information. A Dependent Verification form must be attached for any dependent age 19 up to age 25.								<b>3</b>
FIRST	INITIAL	LAST	SOCIAL SECURITY NUMBER (Required by law if over 1 yr of age)	DATE OF BIRTH	SEX	RELATIONSHIP	TO BE COVERED YES / NO	
List Spouse	<i>Amy</i>	<i>L.</i>	<i>Teacher</i>	<i>123-45-6788</i>	<i>1-18-75</i>	<i>F</i>	<i>Spouse</i>	<input checked="" type="checkbox"/>
List Child								<input type="checkbox"/>
List Child								<input type="checkbox"/>
List Child								<input type="checkbox"/>

<b>REQUIRED OTHER INSURANCE INFORMATION:</b> Do you, your spouse or your children have other medical, dental or vision insurance that you will retain? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If you answered yes, please provide the required information below.			<b>4</b>
SELF: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<b>EMPLOYER NAME, INSURANCE CARRIER NAME &amp; ADDRESS</b>		<b>TYPE OF COVERAGE</b>
SPOUSE: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<i>Bank of Montana</i>		<input checked="" type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS
CHILDREN (LIST) <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Generic Insurance Co.</i>		<input type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS
<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>P.O. Box 6778</i>		<input type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS
<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Helena, MT 59867</i>		<input type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS

STANDARD LIFE INSURANCE COMPANY-BENEFICIARIES					<b>5</b>
Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit	
<i>Amy Teacher</i>	<i>P.O. Box 1234 Somewhere, MT 59104</i>	<i>123-45-6788</i>	<i>Spouse</i>	<i>100%</i>	
Contingent- Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit	
<i>William Teacher</i>	<i>P.O. Box 678, Somewhere, MT 59104</i>	<i>012-34-5678</i>	<i>Father</i>	<i>100%</i>	

I UNDERSTAND that providing inaccurate or incorrect information to any of the answers above may be considered health care fraud. I HEREBY AUTHORIZE my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct. I also realize that dependent coverage not applied for at this time may not be available at a future date.

SIGNATURE OF APPLICANT *Joe L. Teacher* DATE *6-01-05*

## ***Tips for Completing the MUST Enrollment Form***

All fields must be completed as described below to confirm eligibility.

### SECTION 1

#### **Name**

- The employee must indicate his/her legal name.

#### **Employee Mailing Address**

#### **City, State and Zip Code**

- Be certain that the employee fills out his/her address completely.

#### **Telephone Number**

- Indicate a phone number at which the employee can be reached in case of questions about the enrollment form.

#### **Social Security Number**

- Note: If a participant wishes to have an ID number other than their SSN, please make this request in writing and submit it along with the enrollment forms. Social Security Numbers are not printed on identification cards.

#### **Gender (M=Male, F=Female)**

#### **Birth Date**

- Simply note the Month, date and year.

#### **Occupation**

- Frequently this is left blank, but the information is necessary.

#### **Hours Worked Weekly**

- This information is necessary to determine eligibility.

### SECTION 2

#### **Group Number**

- Indicate the District's Group Number.

#### **School District**

- Indicate the name of the school.

#### **Application for**

- Mark the coverages being requested.

#### **Marital Status**

#### **First Day at Work / Requested Effective Date**

- These fields are often left blank, but they are necessary for MUST to determine eligibility and any applicable pre-existing condition exclusion periods.
- The requested effective date must be either the employee's date of hire or the first day of the month following date of hire (unless a different period is required pursuant to a collectively bargained contract).

**Type of Benefits** (Medical, Dental, Vision, according to your group's available options)

**Plan & Deductible Level**

- This is especially important if your district has multiple plan options.

**Plan Status**

- Documentation may be requested in some instances to verify status.

SECTION 3

**Dependent Family Members**

- This section is required if the employee wishes to cover any dependents.
- List all eligible dependents requesting coverage, and check the information for completeness. For dependents age 19 – 25, a Dependent Child Verification form must be completed and submitted with the enrollment form.

SECTION 4

**Required Other Insurance Information**

- This section is required if any of the covered members have other insurance. This information is very important because it allows MUST to coordinate payment of benefits with the other insurance company.
- The Yes or No box must be checked for all applicable persons.
- For Yes answers, complete the employer name, insurance carrier's name and address, and types of coverage.

SECTION 5

**Standard Life Insurance Company – Beneficiaries**

- This section is for active employees only.
- Beneficiary information must be entered for the \$10,000 Basic life insurance policy that is included in the MUST medical plan for active employees.
- A "Contingent" beneficiary is the person(s) who should receive the money if the primary beneficiary dies before the covered employee.

**Signature and Date of Applicant**

- The employee and spouse (if applicable) must sign and date the form. Please be certain the date is included, as this information is used for administrative purposes.

BACK OF FORM

**Health Coverage Waiver Form**

- Employees should complete this section ONLY if they **do not want** to enroll themselves or their spouses in the MUST medical plan.
- Sign and date in the space below the waiver information



**Question:** If a husband and wife are both active employees, do they have to enroll separately in MUST to receive the \$10,000 basic life insurance and basic LTD coverage?

**Answer:** No. The married employees can fill out one green MUST enrollment form as employee and spouse, and then partially complete a second green enrollment form for the spouse only, as follows:

- ~ The spouse should complete **only** Sections 1 and 5, and the Health Coverage Waiver section on the back of the enrollment form.
- ~ Write “LIFE ONLY” prominently on the front of the enrollment form (such as across the Dependent area in Section 3).

This ensures that life insurance beneficiary information is on file for the employee who enrolled in MUST as a spouse.

Note: The above procedure does not apply to retirees, because only active employees are eligible for the basic life and LTD coverage.



**Question:** Why does the clerk or other school official have to review the enrollment form for completeness?

**Answer:** Incomplete forms cause delays. It may have to be returned to the participant for completion, which means that payment of claims may be delayed and a participant may have problems filling prescriptions because their record is not active.