



COMPLETE ALL SECTIONS BELOW FOR NEW ENROLLMENTS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE REVIEW IMPORTANT NOTICES ON THE BACK.	1	Group No: _____	School District: _____	2
Employee Name (FIRST) (MI) (LAST)	Application for: <input type="checkbox"/> Single <input type="checkbox"/> Participant & Spouse <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family			
Address	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated			
City State Zip	First day at work ____/____/____ (Required)			
Telephone No. E-Mail Address	Effective Date as determined by contract or district policy: <input type="checkbox"/> First Day At Work ____/____/____ <input type="checkbox"/> First of the month following first day at work ____/____/____ <input type="checkbox"/> Other ____/____/____			
If you are waiving health benefits stop here. Complete waiver form on the back.		Type of Benefits: <input type="checkbox"/> Medical <input type="checkbox"/> Dental (E) <input type="checkbox"/> Vision (E) (Circle E for Employee Only)		
Social Security # Sex Birth Date	Plan & Deductible Level: Comprehensive Plans (CM): 200 <input type="checkbox"/> 500 <input type="checkbox"/> 750 <input type="checkbox"/> 1000 <input type="checkbox"/> 2000 <input type="checkbox"/> 5000 Revised Plans: <input type="checkbox"/> 200 <input type="checkbox"/> 500 <input type="checkbox"/> 750 <input type="checkbox"/> 1000 <input type="checkbox"/> 1500 <input type="checkbox"/> 2000 <input type="checkbox"/> BP2000 <input type="checkbox"/> HDHP 1200 (EMP) (FAM) <input type="checkbox"/> HDHP 3000 (EMP) (FAM) Copy: <input type="checkbox"/> 70/30 <input type="checkbox"/> 80/20			
Occupation/Job Title Hours Worked Per Week	Plan Status: <input type="checkbox"/> Active <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> COBRA <input type="checkbox"/> Leave Of Absence <input type="checkbox"/> Disabled Qualifying Date: ____/____/____ <input type="checkbox"/> Retired Medicare # _____ & Eff. Date _____			
FOR MUST USE ONLY: Date Entered ____/____/____				
NOTES: _____				

DEPENDENT FAMILY MEMBERS (Please Print) – Complete for each of your dependents and indicate if they are to be covered. Complete the Waiver form on the back if they are not to be covered. You may attach a separate sheet of paper if you need more room for dependent information. If your dependent does not meet the IRS four part dependency test provisions, coverage may have tax consequences. Please review the Senate Bill 419 and Possible Tax Consequences Form.

DEPENDENT FAMILY MEMBERS (list spouse first)			SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	RELATIONSHIP	TO BE COVERED		IF COVERED
FIRST	MI	LAST					YES	NO	Tax Dependent? Yes or No

REQUIRED! OTHER INSURANCE INFORMATION — Do you, your spouse or your children have other medical, dental or vision insurance that you will retain? YES NO If you answered yes, please provide the required information below.

SELF: <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER NAME, INSURANCE CARRIER NAME & ADDRESS	TYPE OF COVERAGE
SPOUSE: <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS
CHILDREN (LIST) <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS
<input type="checkbox"/> YES <input type="checkbox"/> NO	Failure to complete this information will result in a delay of enrollment.	<input type="checkbox"/> MED <input type="checkbox"/> DENT <input type="checkbox"/> VIS

STANDARD LIFE INSURANCE COMPANY-BENEFICIARIES (RETIREES ARE NOT ELIGIBLE)

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent- Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

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 _____

DATE _____

HEALTH COVERAGE WAIVER FORM
(Complete Waiver only if you are waiving coverage for yourself & / or any dependent)

Employer name			Group Name		
Employee Name (FIRST)		(LAST)	(MI)		Social Security Number
I decline to enroll in the coverage from the previous page for: <input type="checkbox"/> Myself			Reason for waiver: <input type="checkbox"/> the existence of other coverage <input type="checkbox"/> other reason (explain)_____		
<input type="checkbox"/> My Dependent Family Members:					
1. _____		3. _____		5. _____	
2. _____		4. _____		6. _____	
<p>I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods", each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period of up to eighteen (18) months for any pre-existing condition, as that term is defined below. <u>I am also waiving the Basic Standard Life Insurance offered with the plan.</u> This does not include employees provided Medical coverage under their spouse's MUST benefits. <u>The Long Term Disability Benefit (LTD) provided by the plan is waived as well.</u> <u>Only members with medical coverage are eligible for the LTD benefit.</u></p>					

SIGNATURE OF APPLICANT

DATE

NOTICES

Special Enrollment Periods. If you are waiving coverage for yourself or your eligible dependents as defined by your Plan (including your spouse) because you or they are currently covered under other health insurance or another health care plan, you may be able to enroll yourself or your dependents for coverage under this plan in the future, provided that you request such coverage within thirty (30) days after such other coverage ends. You or your eligible dependents may also have special enrollment rights in this Plan as a result of :

- The loss of eligibility for coverage under Medicaid or a state sponsored Children's Health Insurance Program (CHIP) if request for enrollment is made within 60 days after loss of such coverage: or,
- Becoming eligible for a premium subsidy from either Medicaid or CHIP for coverage under this Plan, if request for enrollment is made within 60 days after the date of the Determination Letter advising of the eligibility for the premium subsidy, issued by either Medicaid or CHIP You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

Also, if you acquire an eligible dependent, as defined by your Plan, as a result of marriage, birth, adoption or placement for adoption of a child under the age of 18, you may enroll yourself and your newly acquired dependent children or spouse for coverage under this Plan, provided that you request such coverage within thirty (30) days after marriage, birth, adoption or placement for adoption.

An application for coverage must be received in the MUST office within 60 days of the event. Consult your Summary Plan Description for more detailed information.

Pre-existing Condition Exclusion. This health benefit plan may exclude certain medical conditions (either physical or mental) from coverage, if you or an eligible dependent received medical advice, diagnosis, treatment or care for that condition, including prescription medication, within a six (6) month period immediately preceding your enrollment date under this health benefit plan. The enrollment date means the date you or your dependent becomes eligible for coverage under this Plan. The plan will only apply the exclusion to Late Enrollees.

Such pre-existing conditions may be excluded from coverage for a period of eighteen (18) consecutive months beginning on your enrollment date. ***For information specifying the exact time periods referred to in this notice, consult your Plan Administrator, employer, or Summary Plan Description.***

Creditable Coverage. You or your eligible dependent, as defined by this Plan, may submit to the Plan Administrator, certification of Creditable Coverage from any prior health insurance or health care plan under which you or your eligible dependent had coverage, for the purpose of reducing, on a day-for-day basis, the pre-existing condition exclusion imposed by this Plan for any pre-existing condition for which you or your eligible dependent had applicable Creditable Coverage.

You or your eligible dependent have a right to request and receive a Certificate of Creditable Coverage from any insurance carrier or health care plan under which you or your eligible dependent had coverage.

If you are unable to obtain a Certificate of Creditable Coverage from your prior insurance carrier or health plan, the Plan Administrator will provide assistance to obtain the same from your prior carrier or health plan. The Plan also has written procedures to determine Creditable Coverage if you are unable to obtain a Certificate of Creditable Coverage. Please consult the Plan Administrator for more information regarding this procedure.

"Creditable Coverage" means health or medical coverage under which you or your eligible dependent was covered, prior to your enrollment date under this Plan, which prior coverage was under any of the following:

- | | |
|---|---|
| 1. A group health Plan | 6. A medical care program of the Indian Health Service or a tribal organization |
| 2. Health insurance coverage | 7. A state health benefits risk pool |
| 3. Part A or Part B of Title XVII of the Social Security Act | 8. A health plan offered under Chapter 89 of Title 8, United States Code. |
| 4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 | 9. A public health plan including a nationalized health plan of a foreign country |
| 5. Chapter 55 of Title 10, United States Code | 10. A health benefit plan under Section 5(e) of the Peace Corps Act |
| | 11. State Children's Health Insurance Program |

Creditable Coverage for which there has not been a break exceeding sixty-three (63) days prior to a Covered Person's effective date of coverage under this Plan, shall be credited on a day-for-day basis against any pre-existing condition exclusion imposed by the terms of this Plan provided that the prior creditable coverage included coverage for the excluded condition. A **"Certificate of Creditable Coverage"** must include the following information in order for us to determine the exact number of days to be reduced from the **pre-existing condition exclusionary period.**

1. The name or names of the individuals who were previously covered.
2. The date the previous health coverage began.
3. The date the previous health coverage ended.

INSURANCE ID CARDS AND OTHER LIKE DOCUMENTS CANNOT BE ACCEPTED IN LIEU OF CERTIFICATES OF CREDITABLE COVERAGE BUT MAY BE USED AS EVIDENCE OF ANY PRIOR COVERAGE.

All questions about the Pre-existing condition Exclusion and Certificate Coverage should be directed to a *MUST ENROLLMENT SPECIALIST*, by mail at *PO BOX 4579, HELENA, MT 59604-4579* or by phone at *1-800-845-7283*.