ENROLLMENT FORM

MUST
MONTANA UNIFIED SCHOOL TRUST

1

First Name:	MI:	Last Name:

Mailing Address:

City:	State:	ZIP:

Phone:

SSN:	Gender:	Date of Birth:

2

School District Name:	Group No:

First day at work:

OR Special Life Event Date:

Annual salary REQUIRED: $_____
(Used to calculate member's included Long-Term Disability benefit)

Work E-mail:

Title/Classification:	Hours Worked / Week:

3

Please select plan type and individual deductible **from the plan or plans offered by your employer.** If you are waiving medical coverage but your employer offers Tailored Dental and/or Vision and you want to enroll, please skip to section 4. By waiving medical coverage you are acknowledging you are also waiving the Basic Life Insurance and Long Term Disability (LTD) provided by the plan, unless you are covered by MUST as a dependent under another policy provided by the same employer. (If covered under another medical coverage complete the beneficiary section of this application).

PLAN TYPE	INDIVIDUAL DEDUCTIBLE			
☐ BASIC $2000 - 70% - $4000	☐ $ 200	☐ $ 1500	☐ $ 3000	☐ $ 6000
☐ COMPREHENSIVE MAJOR MEDICAL (CM)	☐ $ 500	☐ $ 2000	☐ $ 3500	
☐ HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	☐ $ 750	☐ $ 2500	☐ $ 4000	
☐ REVISED MAJOR MEDICAL (RM)	☐ $ 1000	☐ $ 2700	☐ $ 5000	
☐ BLUE OPTIONS STANDARD (BO)				
☐ BLUE OPTIONS HDHP (BO HDHP)				

4

If offered by your employer, please select Dental and/or Vision coverage.

DENTAL	VISION
☐ Dental ☐ No Dental	☐ Vision ☐ No Vision

5

Employee must be enrolled in Dental and/or Vision coverage for dependent(s) to enroll in Dental and/or Vision.

DEPENDENT FAMILY MEMBERS First M Last	SSN	Date of Birth	Gender M/F	Relationship	Elect Coverage Medical	Dental	Vision
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

6

BASIC AND EMPLOYER PAID LIFE INSURANCE-BENEFICIARIES (RETIREES AND TRUSTEES ARE NOT ELIGIBLE)

Primary – Full Name	Mailing Address	Date of Birth	SSN	Relationship	% of Benefit
Contingent – Full Name	**Mailing Address**	**Date of Birth**	**SSN**	**Relationship**	**% of Benefit**

7 **ENROLLMENT AGREEMENT**

I certify that the information on this form is true and accurate. I UNDERSTAND that providing inaccurate or incorrect information on this form may be considered health care fraud.

_____ _____
SIGNATURE OF APPLICANT **DATE**

FOR MUST USE ONLY: Date Entered ____/____/____

NOTES: _____Q/A INIT_____

Enrollment form revised 03/22/2018