



CHANGE FORM

This form must be returned to your Business Manager/Clerk. Do not submit directly to MUST.

1	School District Name:	Group No:	Effective Date:
----------	------------------------------	------------------	------------------------

- ADDRESS CHANGE
- NAME CHANGE – Please indicate YOUR PRIOR name so we can correctly identify you: _____

FIRST NAME:	MI:	LAST NAME:	LAST 4 OF SSN #:
MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER:			
WORK E-MAIL:			

2 Please indicate type of change below.

DROP HEALTH BENEFITS FOR ALL CHANGE BENEFICIARIES (fill out section 4)

ADD DEPENDENT DROP DEPENDENT

STATUS CHANGED TO RETIRED (You must provide Teachers' Retirement or Public Employees' Systems documentation) DATE: _____

PLAN CHANGE W/ SPECIAL ENROLLMENT: FROM: _____ TO: _____

3	REASON FOR ADD/CHANGE	Date of Event	REASON FOR DROP	Date of Event
	Open Enrollment		Divorce or Legal Separation (Provide address for COBRA notice)	
	Birth, Adoption, Legal Guardianship (attach legal documentation)		Cost	
	Marriage (date of marriage required)		Medicare Eligible	
	Loss of Other Coverage REQUIRED: Reason for Loss of Coverage		Dropping Health Benefit	
	_____		Other Coverage	
	*Proof of loss required		Death	
			Other (explain)	

If you are adding or dropping a Dependent, please list their information below.

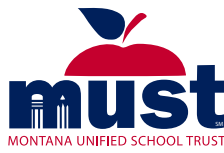
First Name MI Last Name	Gender	Social Security #	Date of Birth	Relationship	Medical		Dental		Vision	
					Add	Drop	Add	Drop	Add	Drop
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF DROPPING COVERAGE: I understand that dropping coverage completely may affect my ability to obtain coverage at a later date for myself and my family, except during applicable "Special Enrollment periods" as defined by the Plan Document. I acknowledge that I am also dropping the Basic Life Insurance and Long Term Disability (LTD) benefit provided by the plan, unless I am covered by MUST as a dependent under another policy provided by the same employer, or employer offers LTD non-medical participating coverage. (If covered under another medical coverage complete the Beneficiary section of this application.)

4 **LIFE INSURANCE BENEFICIARIES (Changes all Life Benefits)**

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

5 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.	FOR MUST USE ONLY: Date Entered ____/____/____
Employee Signature (required) _____	NOTES: _____ Q/A INIT _____
Date _____	



IF YOUR GROUP DOES NOT OFFER VOLUNTARY LIFE, PLEASE DISREGARD THIS PAGE

6	VOLUNTARY LIFE	COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, and your cost, if any.				
VOLUNTARY COVERAGE (check all that apply) Spouse includes Domestic Partner or Party to a Civil Union as defined in the Certificate.		(A) Add, (C) Change, (D) Delete	Total Amount of Coverage Desired		If (C)hanges, list Prior Coverage	
<input type="checkbox"/> Life / AD&D Employee						
<input type="checkbox"/> Life / AD&D Spouse			5K	10K		
<input type="checkbox"/> Life / AD&D Children			5K	10K		
SPOUSE NAME (if Applicant)	LAST	FIRST	M.I.	SEX	SPOUSE DOB	SPOUSE SOCIAL SECURITY #
BENEFICIARY DESIGNATION: (FOR EMPLOYEE ONLY: Must be completed if you have applied for Life/AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to your named surviving primary beneficiaries. If you have no surviving primary beneficiaries, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (NOTE: Employee is the beneficiary of spouse or child coverage proceeds.)						
First Name		Last Name		Social Security #	DOB	Relationship Percentage
Primary						%
Primary						%
Contingent						%
Contingent						%
I hereby request to be insured and authorize deductions, if any, from my compensation. These compensations are for my share of the cost of the benefits to which I may be entitled under the group policy(ies). I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I leave employment that my coverage will terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.						
EMPLOYEE SIGNATURE _____ DATE ____ / ____ / ____						
PRINTED NAME _____ GROUP NAME _____						
WAIVER OF COVERAGE— I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made by my employer.						
EMPLOYEE SIGNATURE _____ DATE ____ / ____ / ____						

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Montana is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

DL9-552-0519 MT

R050119 | Z5222_BCBSMT