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
Open Enrollment	
Birth, Adoption, Legal Guardianship (attach legal documentation)	
Marriage (date of marriage required)	
Loss of Other Coverage **REQUIRED: Reason for Loss of Coverage** _____ *Proof of loss required	

REASON FOR DROP	Date of Event
Divorce or Legal Separation (Provide address for COBRA notice)	
Cost	
Medicare Eligible	
Dropping Health Benefit	
Other Coverage	
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
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

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.

_____

Employee Signature (required) **Date**

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

NOTES: _____Q/A INIT_____

Please see page 2 for Voluntary Life. If your group does not offer Voluntary Life, please disregard.

MONTANA UNIFIED SCHOOL TRUST

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, 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
☐ Life / AD&D	Employee			
☐ Life / AD&D	Spouse		☐ 5K ☐ 10K	
☐ 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 ____/____/____

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