MONTANA UNIFIED SCHOOL TRUST

OPEN ENROLLMENT BENEFIT ELECTION FORM

CLERK

Please complete Section 1, Section 2 (Indicate whether or not the group offers dental and/or vision), Section 4 (Plan Type and Details).

1 **Group Name:** **Benefit Period:** ☐ July ☐ September

2 **DOES GROUP OFFER DENTAL AND VISION BENEFITS?**

Dental Benefits ☐ Yes ☐ No **Vision Benefits** ☐ Hardware Only ☐ Exam/Hardware ☐ No

EMPLOYEE sections 3-6

Please complete **Section 3**, **Section 4** (mark your plan selection for Medical Benefits), and **Section 5** (add or drop coverage for you and/or your dependents). Please sign and date **Section 6** and submit to your District Clerk.

DO NOT complete this form if you are NOT making any changes to your medical, dental and/or vision benefits. This form is ONLY to be used during the Open Enrollment period to make plan changes.

3	First Name:	MI:	Last Name:	Last 4 of SSN:

Current Plan: Select Plan Type and Plan Details

4 **MEDICAL BENEFITS**

EMPLOYEE Mark Selection	CLERK Select Plans Offered by Group	EMPLOYEE Mark Selection	CLERK Select Plans Offered by Group
☐	No Medical Benefits Plan changes	☐	Select Plan Type and Plan Detail
☐	Select Plan Type and Plan Details	☐	Select Plan Type and Plan Details
☐	Select Plan Type and Plan Details	☐	Select Plan Type and Plan Details
☐	Select Plan Type and Plan Details	☐	Select Plan Type and Plan Details

5 **MEMBER INFORMATION**

If you are adding or dropping coverage for yourself or dependents, please list the information below.

First Name MI Last Name	Gender	Social Security #	DOB	Relationship	MEDICAL		DENTAL		VISION			
									Hardware Only		Exam/Hardware	
					Add	Drop	Add	Drop	Add	Drop	Add	Drop
		- -			☐	☐	☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐	☐	☐

IF DROPPING COVERAGE: I understand that dropping medical 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 participant coverage.

6 **I approve the plan changes as indicated above.**

SIGNATURE **DATE**

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

NOTES: _____Q/A INIT_____