# CHOICES 2012/2013 COBRA Annual Open Enrollment Form

**Montana University System’s Flexible Benefits Program**

## Medical Costs

<table>
<thead>
<tr>
<th>Plan</th>
<th>Cost</th>
<th>Employee + Spouse</th>
<th>Employee + Child(ren)</th>
<th>Employee + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Plan</td>
<td>$686.00</td>
<td>$923.00</td>
<td>$899.00</td>
<td>$1,159.00</td>
</tr>
<tr>
<td>PacificSource Managed Care Plan:</td>
<td>$602.00</td>
<td>$810.00</td>
<td>$789.00</td>
<td>$1,017.00</td>
</tr>
<tr>
<td>Blue Cross Blue Shield Blue Choice Managed Care Plan:</td>
<td>$586.00</td>
<td>$789.00</td>
<td>$769.00</td>
<td>$991.00</td>
</tr>
<tr>
<td>Allegiance Managed Care Plan:</td>
<td>$624.00</td>
<td>$839.00</td>
<td>$818.00</td>
<td>$1,053.00</td>
</tr>
</tbody>
</table>

Enter your monthly cost here: $_________ (A)

## Dental Costs

<table>
<thead>
<tr>
<th>Plan</th>
<th>Cost</th>
<th>Employee + Spouse</th>
<th>Employee + Child(ren)</th>
<th>Employee + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium Plan</td>
<td>$44.00</td>
<td>$85.00</td>
<td>$85.00</td>
<td>$121.00</td>
</tr>
<tr>
<td>Basic Plan</td>
<td>$17.00</td>
<td>$32.00</td>
<td>$32.00</td>
<td>$46.00</td>
</tr>
</tbody>
</table>

Enter your monthly cost here: $_________ (B)

## Vision Costs

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Cost</th>
<th>Employee + Spouse</th>
<th>Employee + Child(ren)</th>
<th>Employee + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>$6.90</td>
<td>$13.02</td>
<td>$13.70</td>
<td>$20.08</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter your monthly cost here: $_________ (C)

Your Total Monthly Costs: $_________

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The cost to continue COBRA coverage is up to 102% of the cost of coverage for similarly situated active employees and/or family members. The actual cost is not the same as the amounts used for CHOICES enrollment purposes.

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Check reason you are completing this form:

- New COBRA Enrollment
- Annual COBRA Re-enrollment
- Other

Administrative Use Only

- Campus Location:
- Effective Date:
- Insurance Class:

MUS Employee Name: _______________________________ SSN: _______________________________

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1 Children placed individually on the plan each pay the adult rate.

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MUSCOBRAEF2012

IMPORTANT: COMPLETE BOTH SIDES OF THIS FORM
**Personal**

| Birth Date: | _____/_____/_______ |

COBRA Applicant Name: _____________________

SSN: _____________________

Address: ________________________________

Qualifying Event Date: _____/_____/_____

City: ___________________ State: _______________ ZIP: ________ Sex:  

|   | Male | Female |

|   | Married | Single |

Telephone Number: ________________________________

Sex:  

| Male | Female |

Marital Status:    

| Married | Single |

If your spouse is still an eligible faculty or staff member, please provide his/her name, campus, and Social Security Number.

Spouse’s Name: ________________________________

SSN: ________________________________

Campus: ____________________________________

**List All Eligible Family Members Enrolled for Medical, Dental, or Vision Coverage**

<table>
<thead>
<tr>
<th>Name (Last, First, MI):</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Enrolled in:</th>
<th>Medical</th>
<th>Dental</th>
<th>Vision</th>
<th>SSN</th>
<th>Disabled</th>
<th>Check for Children Over Age 19:</th>
</tr>
</thead>
</table>

| Spouse | _____/_____/_______ | ☐ | ☐ | ☐ | _____________ | ☐ |

| Dependent Child | _____/_____/_______ | ☐ | ☐ | ☐ | _____________ | ☐ |

| Dependent Child | _____/_____/_______ | ☐ | ☐ | ☐ | _____________ | ☐ |

| Dependent Child | _____/_____/_______ | ☐ | ☐ | ☐ | _____________ | ☐ |

| Dependent Child | _____/_____/_______ | ☐ | ☐ | ☐ | _____________ | ☐ |

| Dependent Child | _____/_____/_______ | ☐ | ☐ | ☐ | _____________ | ☐ |

| Dependent Child | _____/_____/_______ | ☐ | ☐ | ☐ | _____________ | ☐ |

| Dependent Child | _____/_____/_______ | ☐ | ☐ | ☐ | _____________ | ☐ |

Please attach list of additional family members.

I understand that any continued coverage elected on this form will terminate immediately upon the occurrence of one of the following events, regardless of whether premiums have been paid for coverage after such event: failure to pay the required premium on time; becoming covered under another group health plan not maintained by the Montana University Systems provided the individual does not have a preexisting condition which the new plan does not cover or due to preclusion or limitation; becoming entitled to Medicare; or termination by the Montana University System of all group health plans for all employees. I also understand that if extended coverage is provided due to Social Security disability, continued coverage will cease if the disabled individual is determined to have recovered. In such cases I will be entitled to a refund of any overpayment of premiums. I authorize the claims administrator or insurance company to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I declare that the information furnished on this form is true, correct and complete to the best of my knowledge. This form supersedes all previous forms I have submitted.

Employee’s Signature: ________________________________ Date: ________________________________