



Montana Municipal Interlocal Authority

EMPLOYEE BENEFITS PROGRAM  
PO Box 6669 ~ Helena, MT 59604-6669

**INDIVIDUAL INITIAL ENROLLMENT FORM**

**COMPLETE ALL SECTIONS BELOW FOR NEW ENROLLMENTS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE REVIEW IMPORTANT NOTICES ON THE BACK.**

<b>Employee Name:</b> Last	First	Initial	Address
<b>Home Telephone No.</b>			City
<b>Work Telephone No.</b>			State
			Zip

<p><b>SECTION 1</b> Have you been previously enrolled in the MMIA EB Program? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If so, date coverage was terminated: ____/____/____</p> <p><i>If you are waiving benefits, stop here. Please complete waiver form on the back.</i></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Social Security No.</td> <td style="width:15%;">Sex</td> <td style="width:25%;">Birth Date</td> <td style="width:35%;"></td> </tr> </table> <p><b>Plan Status: (check one)</b>  <input type="checkbox"/> Active    <input type="checkbox"/> Retired    <input type="checkbox"/> Surviving Spouse    <input type="checkbox"/> Yes    <input type="checkbox"/> No          Do you have Medicare?          If so, please provide copy of card.</p> <p><b>Marital Status: (check one)</b>  <input type="checkbox"/> Single    <input type="checkbox"/> Widowed    <input type="checkbox"/> Divorced    <input type="checkbox"/> Married    <input type="checkbox"/> Separated</p>	Social Security No.	Sex	Birth Date		<p><b>SECTION 2</b> Group No: _____ City/Town of : _____</p> <p><b>Application for: (check one)</b>  <input type="checkbox"/> Single    <input type="checkbox"/> Participant and Spouse  <input type="checkbox"/> Participant and Child(ren)    <input type="checkbox"/> Participant and Family</p> <p><b>First Day of Employment</b> ____/____/____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Occupation/Job Title</td> <td style="width:50%;">Hrs Worked Weekly</td> </tr> </table> <p><b>Selected Medical Plan</b> (Prescription Drug Benefits will be provided as selected by the group)</p> <input type="checkbox"/> Bridger \$500 Ded <input type="checkbox"/> Mission \$1000 Ded <input type="checkbox"/> Madison \$500 Ded <input type="checkbox"/> High Deductible Health Plan \$2700 Ded	Occupation/Job Title	Hrs Worked Weekly
Social Security No.	Sex	Birth Date					
Occupation/Job Title	Hrs Worked Weekly						

**SECTION 3 Complete for yourself and each dependent you want covered. Please check only the boxes that apply to coverages you are electing.**

FIRST	INITIAL	LAST	SOCIAL SECURITY NO. (Required)	DATE OF BIRTH	RELATIONSHIP	SEX	Medical	Dental	Vision	Group Life
Employee:							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse:							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren): (list)							<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"/>

**NOTE: IF YOU OR YOUR DEPENDENTS HAD COVERAGE WITHIN THE LAST 63 DAYS, PLEASE ATTACH VERIFICATION OF CREDITABLE COVERAGE.**

**SECTION 4 ~ REQUIRED ~ OTHER INSURANCE INFORMATION: Do you, your spouse or your children have any other medical, dental or vision insurance?  Yes  No**  
If yes, please provide the required information below.

Self	Yes	No	EMPLOYER NAME, INSURANCE CARRIER NAME & ADDRESS	TYPE OF COVERAGE		
				MED	DEN	VIS
Self	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren): (list)	Yes	No		<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"/>

**SECTION 5 ~ GROUP LIFE INSURANCE ~ BENEFICIARIES (for groups with group life)**

PRIMARY - FULL NAME	ADDRESS	SOCIAL SECURITY NO.	RELATIONSHIP	% OF BENEFIT
CONTINGENT- FULL NAME	ADDRESS	SOCIAL SECURITY NO.	RELATIONSHIP	% OF BENEFIT

**PARTICIPATION CERTIFICATION: I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND I HAVE READ AND UNDERSTAND THE PARTICIPANT AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM. I HERBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY REQUIRED CONTRIBUTIONS FOR THE COST OF BENEFITS FOR WHICH I AM OR MAY BECOME ELIGIBLE.**

Participant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Employer's Signature \_\_\_\_\_ Date: \_\_\_\_\_



**Participant Authorization**

I hereby request coverage for myself and my dependent(s) listed on this enrollment application who are currently enrolled or may become eligible for coverage under the plan agreement purchased by the Montana Municipal Interlocal Authority (MMIA), and I hereby authorize my employer to deduct from my earnings the amount required to cover my share of the Premiums. I agree that my dependents and I will comply with the following:

- ~ That we will be bound by the terms and conditions of the Group Agreement, as it may be amended;
- ~ That all providers that have rendered services to me and my dependents are authorized to make medical information and records regarding such services available to the Plan and their providers who, in turn, may share such records among themselves. Such information may also be released to appropriate governmental agencies; and,
- ~ That I shall assist the Plan in the completion and submission of consents, releases, assignments and any other documents related to the protection of the Plan's rights under the Group Agreement including, but not limited to, the coordination of benefits with other health benefits plans, insurance policies or Medicare. I also agree to pay the cost incurred by the Plan out of any awards, settlements or payments made to me in connection with personal injuries sustained by my dependents or me.

I understand that I am responsible for notifying the Plan within 31 days of any changes in my or my dependent(s)' eligibility status, such as change of address, birth, adoption of a child, marriage, termination or additional coverage..

**Health Coverage Waiver – (Complete this section only if you are waiving coverage for yourself and/or any dependent)**

**If waiving coverage upon initial eligibility and want to continue to waiver coverage during the next open enrollment period, you must sign a waiver every plan year during open enrollment. Proof of other creditable group coverage is required with the submission of this waiver.**

I decline to enroll in coverage with the MMIA for:  Myself  My Spouse  My Dependent Child(ren)  
(please print)

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Reason for waiver:

Existence of Other Group Coverage

Other: \_\_\_\_\_  
Please provide explanation of other

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Enrollment Periods" each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period of up to eighteen (18) months for any pre-existing condition, defined below.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Pre-existing Condition Exclusions.** This health benefit plan may exclude certain medical conditions (either physical or mental) from coverage, if the person to be covered received medical advice, diagnosis treatment or care for that condition within a period not to exceed 6 months immediately preceding that person's enrollment date under this health benefit plan. Such pre-existing conditions may be excluded from coverage for a period not to exceed 1 year, if that person failed to enroll for coverage under this health benefit plan at the earliest date that the person was eligible to enroll. For information specifying such exclusions or the exact time period referred to in this notice consult your employer or the MMIA.

**Special Enrollment Periods.** If you are waiving coverage for yourself /dependent/spouse because you or they are currently covered under other health insurance or another health care plan, you may be able to enroll yourself/dependent/spouse for coverage under this plan in the future provided that you request such coverage within 30 days after other coverage ends. In addition if you acquire a new dependent including a spouse as a result of marriage or child/children as a result of birth, adoption, adoption placement, you may be able to enroll yourself or your newly acquired dependent/spouse for coverage under this plan and not be considered a late enrollee provided that such enrollment occurs within 30 days after the marriage, birth, adoption, or adoption placement.

**Creditable Coverage.** An eligible employee or dependent may submit to the MMIA a Certification of Creditable Coverage from any prior health insurance under which employee/dependent/spouse had coverage for the purpose of reducing any exclusions imposed by the Plan for pre-existing condition for which the employee/dependent/spouse had applicable Creditable Coverage under any prior health care plan. An eligible employee/dependent/spouse has a right to request and receive a Certificate of Creditable Coverage from any insurance carrier or health plan under which he/she had coverage on or after July 1, 1996. Creditable Coverage means health or medical coverage under which a covered person was covered prior to enrollment date under this plan which prior coverage was under any of the following: 1) A Group Health Plan; 2) Health Insurance Coverage; 3) Part A, Part B, or Part C of Title XVIII of the Social Security Act; 4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; 5) Chapter 55 of Title 10 United States Code 6) A medical care program of the Indian Health Service or a tribal organization; 7) A state health benefits risk pool; 8) A health plan offered under Chapter 89 of Title 5 United States Code; 9) A public health plan; 10) A health benefit plan under Section 5(e) of the Peace Corps Act