Legislator Opt Out/Waiver Form

Use this form to opt-out/waive State of Montana Benefit Plan (State Plan) coverage.

This form **must be postmarked or returned by the 25th of the month prior to the month in which you wish to opt out/waive coverage or receive reimbursement as outlined below** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130.

Personal Information

Last Name _____ First Name _____ MI ___

Date of Birth _____ Last Four of SSN _____

Mailing Address_____

City _____ State _____ Zip _____

Phone Number _____

Email (optional) _____

Opt Out/Waiver of State Plan Coverage

Check this box to opt out/waive State Plan coverage.

- ❑ I have been given the opportunity to enroll in the State Plan and decline participation at this time. Myself and any eligible spouse, domestic partner, and/or dependent children will not be covered by the State Plan (including medical, dental, and basic life). A benefit eligible Legislator may re-enroll at any time, but spouse, domestic partners, and/or dependent children will not be able to enroll on the State Plan until the next Open Enrollment period or with a Special Enrollment Period as outlined in the Wrap Plan Document.

Opt Out Reason – Indicate the reason for opting out of State Plan coverage.

- ❑ Enrolled in another Employer Group Health Plan with minimum essential coverage (as an employee or a dependent).
- ❑ Enrolled in Medicare and/or Medicare Supplement or Advantage Plan. ***Reimbursement not available.**
- ❑ Enrolled in individual coverage through an insurance carrier or the Health Insurance Marketplace. ***Reimbursement not available.**
- ❑ Other: _____

If a Legislator opts out/waives State Plan coverage, the Legislator may be eligible to receive reimbursement, up to $1,080 per month, for premiums paid by the Legislator in conjunction with an Employer Group Health Plan or premiums paid for certain types of disability insurance and life insurance as defined below. The State Plan is restricted by federal regulation from providing reimbursement for Medicare, Medicare Supplement, Medicare Advantage, individual coverage through an insurance carrier, or Health Insurance Marketplace premiums. Reimbursement of any kind is not available if the Legislator has enrolled on the State Plan.

Be Aware: If a Legislator opts out/waives State Plan coverage and requests reimbursement, any reimbursement provided is taxable income to the Legislator. HCBD advises Legislators who wish to receive this reimbursement, in lieu of State Plan coverage, to consult with their personal tax advisor.

MCA 33-1-207. Disability insurance. (1) Disability insurance, including credit disability insurance, is insurance of human beings:

(a) against bodily injury, disablement, or death by accident or accidental means or the medical expense or

indemnity involved; or

(b) against disablement or medical expense or indemnity resulting from sickness.

(2) Transaction of disability insurance does not include workers' compensation insurance.

MCA 33-1-208. Life insurance. Life insurance, including credit life insurance, is insurance on human lives. The transaction of life insurance includes the granting of endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured's disability, benefits that provide reimbursement or payment for long-term home health care or long-term care in a nursing home or other related institution, and optional modes of settlement of proceeds of life insurance. Transaction of life insurance does not include workers' compensation insurance.

To receive reimbursement, up to $1,080 per month, for Employer Group Health Plan coverage, disability insurance, or life insurance as defined above, complete the below reimbursement request and provide documentation, from your Employer Group Health Plan, disability insurance carrier, or life insurance carrier showing type of coverage and the amount of monthly premium for each policy type in which reimbursement is being requested.

Employer Group Health Plan Coverage: $_____

** Must certify below that coverage meets the minimum essential coverage requirements.

Disability Insurance:

- Dental $_____
- Vision $_____
- Long Term Care $_____
- Cancer $_____
- Accident $_____
- Other $_____

Life Insurance (Term): $_____

Total Reimbursement Requested: $_____

All reimbursements will be completed via the State of Montana payroll system and will be subject to tax withholding.

Read and Sign

By signing this form, I certify I am declining to enroll in the State of Montana Benefit Plan (State Plan coverage). If I am requesting reimbursement for coverage under another Employer Group Health Plan, that coverage meets minimum essential coverage requirement for myself and all eligible tax qualified dependents. If I am requesting coverage for a disability insurance policy or life insurance policy, that coverage meets the definition of disability insurance as defined by MCA 33-1-207 or life insurance as defined by MCA 33-1-208. I must notify the Health Care & Benefits Division (HCBD) of any mid-year changes that alter the reimbursement amount I am entitled to receive.

I understand by signing below, I agree to the above Authorization Terms.

Signature:_____ Date:_____

Language Assistance – General Taglines

State of Montana is required by federal law to provide the following information.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-270-3877（TTY：711)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-270-3877 (TTY:711）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-270-3877 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-270-3877 (ATS : 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-270-3877 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비ㅅ를 무료로 이용하실 수 있습니다. 1-866-270-3877 (TTY: 711)번ᄋᆞ로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-668-072-7783 (رقم هاتف الصم ،_البكم: 117).

เรียน:'U: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-866-270-3877 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-270-3877 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-270-3877 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-270-3877 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-270-3877 (TTY: 711).

State of Montana Non-Discrimination Statement: State of Montana complies with applicable Federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact customer service at 855-999-1062. If you believe that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status you can file a grievance. If you need help filing a grievance the State Diversity Coordinator is available to help you. You can file a grievance in person or by mail, fax, or email: State Diversity Program Coordinator - Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3871 Email: SABHRSHR@mt.gov.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).