Monica J. Lindeen
CSI | Insure Montana
Montana Commissioner of Securities & Insurance

EMPLOYEE ASSISTANCE OPT-IN FORM

Complete and return to: 840 Helena Avenue
Helena, MT 59601
Fax: 406-444-3435
Phone: 406-444-2040
Toll Free: 800-332-6148

By completing this form, employees are agreeing to have their premium assistance payments go directly to the employer.

Business Name:_____

Employer Bank Information: ATTACH A VOIDED CHECK TO THIS FORM. (Do not send deposit slips)
Name on Account: _____
Transit Routing Number (9 digits): _____
Bank Account Number (include zeros, do not include check number): _____
Type of Account (select only one): ____ Checking ___ Savings
Date Bank Account Opened: _____/_____/_____
Financial Institution Name: _____
Bank Address: _____
City: _____ State: _____ Zip: _____
Bank Phone Number: _____ Ext: _____

Deposit my premium assistance payments directly into my employer's account.

***NOTE: By agreeing to have premium assistance payments deposited in your employer's account, you are agreeing to allow your employer to learn the amount of the premium assistance subsidy you receive each month.)*

Employee Name (print name):
Employee Signature: Date:
Employee Name (print name):
Employee Signature: Date:
Employee Name (print name)
Employee Signature: Date:
Employee Name (print name):
Employee Signature: Date:
Employee Name (print name):
Employee Signature: Date:

This agreement can be nullified by notifying Insure Montana in writing that you no longer want to Opt-In. All changes will take effect on the next scheduled payment.