

EMPLOYEE PREMIUM ASSISTANCE APPLICATION

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

Instructions: This two page application must be completed by the **ELIGIBLE EMPLOYEE**, signed and submitted along with a change report form within 30 days from the date that the employee is added to the health insurance plan. Failure to complete or submit this application within 30 days will result in the premium incentive and assistance subsidy effective with the next scheduled payment date and ineligibility for any previous month's subsidy payments regardless of the date the employee was added to the health insurance plan. If you have questions contact the Insure Montana office at (800) 332-6148 or (406) 444-2040.

EMPLOYEE DEMOGRAPHIC INFORMATION (all fields required)

Business Name		Date Employee is Eligible for Health Insurance (mm/dd/yy)		
First Name		M/I	Last Name	
Social Security Number	Date of Birth		Work Telephone Number	
Home Telephone Number	Cell Number		Email Address (please print clearly)	
Physical Address (required, No P.O. Boxes)			City/State/Zip	
Mailing Address (if different)			City/State/Zip	
Are you an owner of the business? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you individually earn more than \$75,000 annually from the business? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you want to receive an Electronic Fund Transfer receipt by E-mail to the address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No				

HOUSEHOLD MEMBERS (required)

List ALL household members that reside in the home more than 50% of the year including dependents attending college, even if they are not enrolling in this group health policy. Attach additional page if necessary.

Name (First, M/I, Last)	Relationship to Employee	Social Security Number	Date of Birth (mm/dd/yy)	Enrolling? Y or N - List name of other Insurance if <u>not</u> enrolling.

HOUSEHOLD INCOME (required)

List total household gross (before taxes) annual income from all sources, including: wages, Social Security or disability benefits, worker's compensation, unemployment, distributions, etc.

Single:	Married (no children):	Single with children:	Family (married with children):
___ Less than \$9,570	___ Less than \$12,830	___ Less than \$16,090	___ less than \$19,350
___ \$9,571 - \$14,355	___ \$12,831 - \$19,245	___ \$16,090 - \$24,135	___ \$19,351 - \$29,025
___ \$14,356 - \$19,140	___ \$19,246 - \$25,660	___ \$24,136 - \$32,180	___ \$29,026 - \$38,700
___ \$19,141 - \$23,925	___ \$25,661 - \$32,075	___ \$32,181 - \$40,225	___ \$38,701 - \$48,375
___ \$23,926 - \$28,710	___ \$32,076 - \$38,490	___ \$40,226 - \$48,270	___ \$48,376 - \$58,050
___ \$28,711 and over	___ \$38,491 and over	___ \$48,271 and over	___ \$58,051 and over

PAYMENT INFORMATION

(Select ONE)

I elect to receive a paper check for my monthly premium assistance payment.

Bank Account Opt-In – By opting-in, I am agreeing to have my employee premium assistance payments deposited into my employer’s bank account, and therefore I agree to allow my employer to learn the amount of the premium assistance subsidy I receive each month. **Initials** _____

Electronic Funds Transfer

Information collected will be used for Electronic Funds Transfer (EFT) to deposit your monthly premium assistance amount. **Please include a voided check with this form.** If a voided check is not available, attach a letter from your financial institution indicating the bank transit routing and account numbers. The document must be on bank letterhead and signed by a bank official.

Financial Institution Name: _____

Transit Routing Number (9 digits): _____

Bank Account Number (include zeros, do not include check number): _____

Type of Account (please mark **one** only): _____ Savings _____ Checking

Name on account: _____

Bank Address: _____

City: _____ State: _____ Zip: _____

Bank Telephone Number: _____ Ext: _____

Please attach voided check in this space. Do not send deposit slips.

CERTIFICATION AND SIGNATURE

Unsigned applications are considered incomplete. Please read the information and sign below:

I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.

Employee Signature _____ **Date** _____