

INSURE MONTANA

TAX CREDIT PROGRAM CHANGE REPORT

Please complete and return to: **Insure Montana**
840 Helena Avenue
Helena, MT 59601
Fax: 406-444-3497

Effective Date of Change: _____

Business Name: _____

Employee Name: _____ Age: _____

Insurance Agent Name: _____

TYPE OF CHANGE

____ New employee (must complete information below)

____ Delete employee and all dependents; effective date: _____

____ Add spouse/dependent(s) (must complete information below)

____ Delete spouse/dependents(s); effective date: _____

____ Change in health insurance coverage: _____

____ Other (explain) _____

Comments: _____

NEW EMPLOYEE CHANGES

Employee Name: _____

Social Security No.: _____

Date of Birth: _____

Date added to coverage: _____

Employee Premium: \$ _____

Business Contribution: \$ _____

Amount Business Contributes

for Spouse: \$ _____

Date Spouse Added: _____

Amount Business Contributes for

Dependent(s): \$ _____

Date Dependent(s) Added: _____

NOTE: Do not count spouse as dependent

*Forms and other pertinent information can be found on the Insure Montana website at: insuremontana.org

CERTIFICATION AND SIGNATURE

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 form if requested. I understand that State staff may obtain documents and/or information to verify statements on this form.

Signature _____ **Date** _____