

## TAX CREDIT CHANGE FORM

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

Business Name	Insurance Agent Name
Employee Name	
<b>EMPLOYEE CHANGE</b>	
Note: Do not count spouse as a dependent	
<input type="checkbox"/> Add New Employee	Employee Monthly Premium \$
Effective date of group health coverage for employee	Business Contribution for Employee per month \$
Employee Name	Business Contribution for Spouse per month \$
Social Security Number	Business Contribution for Dependent(s) per month \$
Date of Birth	Number of dependent(s)
<input type="checkbox"/> Delete Employee and all Dependents as of this date (mm/dd/yyyy)	
<b>SPOUSE CHANGE</b>	
<input type="checkbox"/> Add Spouse as of this date (mm/dd/yyyy)	Amount business contributes for Spouse each month: \$
<input type="checkbox"/> Delete Spouse as of this date (mm/dd/yyyy)	
<b>DEPENDENT CHANGE</b>	
Note: Do not count spouse as a dependent	
<input type="checkbox"/> Add Dependent(s) as of this date (mm/dd/yyyy)	Amount business contributes for Dependent(s) each month: \$
	Number of Dependent(s)
<input type="checkbox"/> Delete Dependent(s) as of this date (mm/dd/yyyy)	
<b>OTHER CHANGES</b>	
<input type="checkbox"/> Change in Health Insurance coverage: (provide name of new health insurance carrier and a copy of a current monthly premium statement)	
<input type="checkbox"/> Other (please explain)	
<b>CERTIFICATION AND SIGNATURE</b>	
<i>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.</i>	
<b>Signature</b>	<b>Date</b>