MISSOULA COUNTY

Missoula County Employee Benefits Plan
200 W. Broadway
Missoula MT 59802-4292
(406) 523-4876 Fax (406) 523-4731

Health Benefits Annual Information Request

(This is not an Enrollment Form)

You must complete this form annually.

1. General information

Employee name: **Social Security or ID #**

Mailing address:
Street or P.O. Box City Zipcode

Employer/department: **Contact #**

Who is covered under your Missoula County Medical Benefits Plan?

Name	Relationship to you	Birthday

2. Other insurance information for each member listed above

Do you or any family member(s) have other medical, dental or vision coverage insurance? Yes ☐ No ☐
If you marked "No" to the above questions, you may skip to the bottom of the page and sign. If yes, please complete the following section.

Who is covered under this policy?
Insurance company name
Mailing/street address
City **State** **Zip**
Telephone
Effective date of coverage
Name of policyholder **Date of birth**
Policyholder ID # **Social Security #** **Group #**
Mark the box next to type of coverage(s): ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Prescription**
Name of employer providing this coverage
Are you retired from this employer? Yes ☐ No ☐

If more than one policy, please attach an additional page.

3. Legal Custody/Guardianship Information

Child's name	Name of person with custody	Relationship to child	Who is named in divorce decree as responsible for health insurance?

I certify the above information is accurate and complete to the best of my knowledge.

Employee signature **Date**