MISSOULA COUNTY

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

Yearly Update Request (This is not an Enrollment Form)

1. General information

Name: Insurance ID #

Please Print

Mailing Address:

Street or P.O. Box City Zipcode

Msla. Co. Dept.Name: Contact #

Please list who is covered under your Missoula County Medical Benefits Plan

Name	Relationship to you	Birthday

2. Please list any other insurance information for each member listed above:

Do you or the family member(s) listed above 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: Must provide court ordered documentation

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:**