Yearly Update Request

THIS IS NOT AN ENROLLMENT/CHANGE FORM

MISSOULA COUNTY EMPLOYEE BENEFITS PLAN

Mailing Address: 200 West Broadway
Physical Address: 223 West Alder Street
Missoula, MT 59802-4292

P: 406.258.4876 | F: 406.258.4731
E: benefits@missoulacounty.us

Missoula COUNTY

General information

Name: Insurance ID #:

Please Print

Mailing Address:

Street or P.O. Box City Zip code

Department Name: Phone #:

Please list all family members currently covered under your Missoula County Medical Benefits Plan:

Name	Relationship to you	Birthday	Social Security Number

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 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.

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: