MISSOULA COUNTY
BENEFITS ENROLLMENT/CHANGE

Please print legibly

Indicate purpose:
- ☐ **Initial enrollment**
- ☐ **Special Enrollment**
- ☐ **Open Enrollment**
- ☐ **Delete Spouse/Dependent**
- ☐ **Termination**

NAME: _____ SSN: _____
First Last
ADDRESS: Street _____

City _____ State _____ Zip _____ Home Phone #_____

DATE OF BIRTH: _____ MARITAL STATUS: _____ GENDER/PRONOUN: _____

DEPARTMENT: _____ EMPLOYMENT DATE:_____

BENEFIT STATUS – I WORK: ☒ 26-40 HRS/WEEK ☐ 20 TO <26 HRS/WEEK

INDICATE TYPE OF COVERAGE REQUESTED:

Health:	Single ☐	**Dental:**	Single ☐	**Optical:**	Single ☐
	Family ☐		Family ☐		Family ☐
	Employee/Spouse/DP ☐		Employee/Spouse/DP ☐		Employee/Spouse/DP ☐
	Employee/Child(ren) ☐		Employee/Child(ren) ☐		Employee/Child(ren) ☐

Changes- Reason and Date:_____

LIST BELOW ALL PERSONS (INCLUDING SELF) FOR WHOM YOU ARE **REQUESTING** OR **DELETING** COVERAGE.

NAME	DATE OF BIRTH	SS#	RELATIONSHIP & GENDER/PRONOUN	COVERAGE REQUESTED					
				MEDICAL		DENTAL		OPTICAL	
				Yes	No	Yes	No	Yes	No

I hereby request the coverage indicated above and authorize Missoula County to deduct any required contribution from my paycheck. **(Complete back page for new or added coverage.)**

SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY HUMAN RESOURCES OFFICE:

	MEDICAL	DENTAL	VISION	LTC	SUPPLIFE /LIFE	SLTD/LTD
EMPLOYEE SHARE						
COUNTY SHARE						
TOTAL:				OTHER ENROLLMENT FORM NEEDED		
COVERAGE EFFECTIVE DATE						
EFFECTIVE -PAY DATE						
COVERAGE TERMINATION DATE						

Flex? _____ Ross deduction start date -_____ PP- _____

Medspfx start -_____ Amount per year -_____ Amount per pp -_____

(Rev. 1/2022) *Reviewed by Benefits Staff Initial _____* *Sent to HR Date_____*

SWORN STATEMENT - MISSOULA COUNTY EMPLOYEE BENEFITS PLAN

EMPLOYEE NAME: _____ SOCIAL SECURITY NO: _____

MARRIAGE

I declare under penalty of perjury that my lawful spouse is _____ and that we are married under the laws of the State of Montana.

I understand that I must provide proof of marriage or common law if requested to do so by the Plan Administrator. I understand further that I must inform the Missoula County Human Resources Office immediately of any change in my marital status.

DEPENDENTS

I declare under penalty of perjury that my eligible dependents are:

_____ Dependent children under age 26 who are otherwise eligible in accordance with the Plan (see Eligibility and Participation section of Plan document).

I understand that I must provide proof of dependency if requested to do so by the Plan Administrator. I understand further that I must inform the Missoula County Human Resources Office immediately of any change in stated eligibility.

DOMESTIC PARTNERS

We, _____, employee, and _____, domestic partner, each certify and declare under penalty of perjury that we are each other's sole domestic partner as set out below.

- We are both at least eighteen years old; and
- We have lived together on a continuous basis for at least twelve months in a common residence; and
- Neither of us is married to or legally separated from any other person; and
- Neither of us is engaged in another domestic partnership; and
- We are not related by blood or marriage; and
- We are engaged in a committed relationship of mutual caring and support and intend to remain so indefinitely; and
- We are financially interdependent and will, on request, provide documentation of joint financial responsibility.

We agree to notify the Human Resources Office within thirty days of the termination of our domestic partnership under the above criteria. We understand that termination of domestic partner and dependents of domestic partner benefits coverage will be effective on the date that the domestic partnership ended.

We understand and acknowledge that this Declaration may have legal implications including the taxability of benefits provided and that the Employer has advised us to consult an attorney regarding the legal consequences of signing this Declaration.

I wish to enroll: ☐ my domestic partner
☐ my domestic partner and dependent children of my domestic partner

The person(s) I wish to enroll qualifies as my tax dependent(s) under the Internal Revenue Code: ☐ YES ☐ NO
If you cannot legally answer yes, all employer** contributions for domestic partner coverage will be treated as taxable income.

Under penalty of law (MCA 45-7-203 Unsworn Falsification to Authorities) the statements made on this form are true and correct to the best of my knowledge, information and belief.

DOMESTIC PARTNER SIGNATURE _____ DATE _____

Under penalty of law (MCA 45-7-203 Unsworn Falsification to Authorities) the statements made on this form are true and correct to the best of my knowledge, information and belief.

EMPLOYEE SIGNATURE _____ DATE _____