

INSURE MONTANA

EMPLOYEE PREMIUM ASSISTANCE APPLICATION

Please complete and return to: **Insure Montana**
 840 Helena Avenue
 Helena, MT 59601
 Fax: 406-444-3435

THIS APPLICATION MUST BE COMPLETED, SIGNED AND SUBMITTED WITH A CHANGE REPORT FORM WITHIN **30 DAYS** FROM THE DATE THAT THE EMPLOYEE IS ADDED TO THE HEALTH INSURANCE PLAN. BOTH PAGES MUST BE SUBMITTED EVEN IF NOT PROVIDING BANK INFORMATION. FAILURE TO COMPLETE OR SUBMIT THIS APPLICATION WITHIN **30 DAYS** WILL RESULT IN THE PREMIUM INCENTIVE AND ASSISTANCE SUBSIDY EFFECTIVE WITH THE NEXT SCHEDULED PAYMENT DATE AND INELIGIBILITY FOR ANY PREVIOUS MONTH'S SUBSIDY PAYMENTS REGARDLESS OF THE DATE THE EMPLOYEE WAS ADDED TO THE HEALTH INSURANCE PLAN. IF YOU HAVE QUESTIONS CONTACT THE INSURE MONTANA OFFICE AT 406-444-2040 or 800-332-6148.

THE EMPLOYEE MUST COMPLETE ALL OF THE FOLLOWING INFORMATION:

DEMOGRAPHIC INFORMATION

First Name	M/I	Last Name	Employer/Business Name	
Address		City	State	Zip Code
Mailing Address if Different		City	State	Zip Code
Home #	Work #	Other Phone#	Email Address* (please print clearly)	
Are you an owner of the business? <input type="checkbox"/> YES <input type="checkbox"/> NO If <u>YES</u> , do you individually receive more than \$75,000 annually from the business? <input type="checkbox"/> YES <input type="checkbox"/> NO				
*Do you want to receive an Electronic Fund Transfer receipt by e-mail to the address listed above? <input type="checkbox"/> YES <input type="checkbox"/> NO				

LIST ALL HOUSEHOLD MEMBERS THAT RESIDE IN THE HOME MORE THAN **50%** OF THE YEAR INCLUDING DEPENDENTS ATTENDING COLLEGE (ATTACH AN ADDITIONAL PAGE IF NECESSARY):

HOUSEHOLD MEMBERS

Name (First, M/I, Last)	Relationship to Employee	Include in Insure MT Yes or No; OR, List name of insurance company if other than Insure MT BCBS.	Social Security Number	Date of Birth	Fulltime College Student (Yes or No)

LIST HOUSEHOLD ANNUAL GROSS (BEFORE TAXES) INCOME FROM ALL SOURCES, INCLUDING: WAGES, SOCIAL SECURITY OR DISABILITY BENEFITS, WORKER'S COMP, UNEMPLOYMENT COMP, ETC.

HOUSEHOLD INCOME

Check the box that applies to your total annual gross household income:

Single:	Married (no children):	Single with children:	Family (married with children):
<input type="checkbox"/> less than \$9,570	<input type="checkbox"/> less than \$12,830	<input type="checkbox"/> less than \$16,090	<input type="checkbox"/> less than \$19,350
<input type="checkbox"/> \$9,570- \$14,355	<input type="checkbox"/> \$12,830- \$19,245	<input type="checkbox"/> \$16,090- \$24,135	<input type="checkbox"/> \$19,350- \$29,025
<input type="checkbox"/> \$14,355- \$19,140	<input type="checkbox"/> \$19,245- \$25,660	<input type="checkbox"/> \$24,135- \$32,180	<input type="checkbox"/> \$29,025- \$38,700
<input type="checkbox"/> \$19,140- \$23,925	<input type="checkbox"/> \$25,660- \$32,075	<input type="checkbox"/> \$32,180- \$40,225	<input type="checkbox"/> \$38,700- \$48,375
<input type="checkbox"/> \$23,925- \$28,710	<input type="checkbox"/> \$32,075- \$38,490	<input type="checkbox"/> \$40,225- \$48,270	<input type="checkbox"/> \$48,375- \$58,050
<input type="checkbox"/> \$28,710 and over	<input type="checkbox"/> \$38,490 and over	<input type="checkbox"/> \$48,270 and over	<input type="checkbox"/> \$58,050 and over

PAYMENT INFORMATION

If you would like your premium assistance payment deposited directly into your bank account, please complete the following information and provide a copy of a voided check; otherwise, you will receive payment via a paper check.

Bank Account Information

Information collected will be used for Electronic Funds Transfer (EFT) to deposit your monthly premium assistance amount. **Please include a voided check with this form.** If a voided check is not available, attach a letter from your financial institution indicating the bank transit routing and account numbers. The document must be on bank letterhead and signed by a bank official. **Deposit slips are not acceptable.**

Financial Institution Name: _____

Transit Routing Number (9 digits): _____

Bank Account Number (include zeros, do not include check number): _____

Name on account: _____

Type of Account (please mark **one** only): _____ Savings _____ Checking

Date Bank Account Opened: ____/____/____

Bank Address: _____

City: _____ State: _____ Zip: _____

Bank Phone Number: _____ Ext: _____

Please attach voided check in this space.

CERTIFICATION AND SIGNATURE

Unsigned applications are considered incomplete. Please read the information and sign below:

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 application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.

Employee Signature: _____ **Date:** _____