Montana Automobile Dealers Insurance Trust

HEALTH INSURANCE ENROLLMENT/CHANGE/TERM FORM

Please fax: 406-449-0119 DO NOT EMAIL

American Fidelity groups only - Please use this form for Changes and Terminations

Last Name	First Name	Initial	Home/Cell Phone

Current Address	City	State	Zip

Employer: **Occupation:** **Group Number:** **700**

SECTION 1 ~ *Please fill out the section below that applies to enrollment changes or terminations of coverage*

Part A - Enrollment Changes

Qualifying Event - Check box that applies	Qualifying Event Date
❑ Marriage	
❑ Divorce	
❑ Birth	
❑ Adoption	
❑ Ineligible Dependent - name of dependent	
❑ Address Change: new address	
❑ Other: Explain	

Medical Plan Choice - Qualifying Events Only - Check only one box **Must provide proof of Qualifying Event**

❑ Trad 70/30 ❑ Trad 60/40 ❑ Trad 50/50 ❑ HDHP 2700 ❑ HDHP 4500

Notes:

Part B - Termination of Coverage

Last day worked ____ Last day eligible for benefits ____

☐ Voluntary by employee ☐ Involuntary by employer

Type of Qualifying Event (Term, Resignation, Reduce Hrs, Death): ____

Coverage will end the last day of the month in which employee was terminated.

SECTION 2 ~ Indicate change requests by checking only boxes that apply to your life change *All coverages may not apply to your group*

FIRST MI LAST *New enrollee - must complete employee info also*	SOCIAL SECURITY # (Required)		RELATIONSHIP	Sex	Medical		Vision		Dental	
					Add	Drop	Add	Drop	Add	Drop
Employee:					☐	☐	☐	☐	☐	☐
Spouse:					☐	☐	☐	☐	☐	☐
Child(ren): (list)					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

PARTICIPATION CERTIFICATION: I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWELDGE. I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY REQUIRED CONTRIBUTIONS FOR THE COST OF BENEFITS FOR WHICH I AM OR MAY BECOME ELIGIBLE.

I acknowledge that coverage has been offered to me and I elect not to participate at this time because:

Waiver of Participation: ____

Employee Signature: ____ **Date:** ____________________

Participant's Signature (*changes only*) Date:

Employer's Signature Date:

Rev 12.21.15