HEALTH PROFESSIONS OF MONTANA PLAN & TRUST

ENROLLMENT FORM

Clear Form

Group Name: Date:

First Name: MI: Last Name:

Mailing Address:

City: State: Zip: Phone:

SSN: DOB: Email:

Hire Date: Gender: Hours Worked/Week:

ENROLLMENT:

☐ New Hire (subject to employer waiting period) *Effective Date: *These dates must be first of the month. Coverage cannot begin mid month.

☐ Current employee newly eligible based on hours Eligible Date: *Effective Date:

☐ Qualifying Event (may require documentation): *Date:

☐ Open Enrollment *Effective Date: *Please note that effective date of coverage must be the 1st of the month following waiting period, event, or open enrollment period.

DEPENDENT FAMILY MEMBERS:

Spouse/Domestic Partner

First	M	Last	SSN	Date of Birth	M/F	Date of Marr/Partnership	Med	Den	Vis

Dependent Child/ren

SECONDARY COVERAGE: ◯ I/My dependents do not have other coverage ◯ I/My dependents have other coverage

List other coverage:

MEDICAL PLAN CHOICE: Employer: please select plan/s offered from drop down (PDF) or write in employee plan option/s.

Employee: use check box to choose a plan.

◯ Plan 1 ◯ Plan 2 ◯ Plan 3

ANCILLARY OPTIONS: (If offered by Employer)

Dental ◯ Yes ◯ No Vision ◯ Yes ◯ No Voluntary Life ◯ Yes ◯ No

ENROLLMENT AGREEMENT - I certify that the information on this form is true and accurate. I UNDERSTAND that providing inaccurate or incorrect information on this form may be considered health insurance fraud and may result in denial or cancellation of coverage from its beginning.

Signature of Applicant:: Date:

Signature of Employer: Date:

EMPLOYER: This enrollment form has been reviewed by the Employer group to confirm that the employees and/or family members who are enrolled or applying for enrollment meet all eligibility requirements of the HPMPT under the Plan Document and SPD and the Adoption Agreement between the HPMPT and the Employer Group. You may make changes 1) directly on SIMON enrollment system or 2) you may fax to 406-502-1017 or SECURE email this form to ksweeney@hpmpt.org.

IMPORTANT - For HPMPT purposes, please keep this form and any verifying documentation needed on file for a minimum of four years.

HEALTH PROFESSIONS OF MONTANA PLAN & TRUST

The Standard Insurance Company

Beneficiary Form

Group Name:

First Name: MI: Last Name:

To Be Completed By Applicant

Life Insurance:

X Basic Life with AD&D $ 10,000

Beneficiary Information: This designation applies to your Life and Accidental Death and Dismemberment Insurance Basic Life policy available through your Employer. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary—Full Name	Address	DOB	Phone #	SSN *if known*	Relationship	% of Benefit
1.						%
2.						%
3.						%
					% of Benefit must equal	100%

Contingent—Full Name	Address	DOB	Phone #	SSN *if known*	Relationship	% of Benefit
1.						%
2.						%
3.						%
					% of Benefit must equal	100%

Signature: I wish to make the choices indicated on this form. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim.

Signature of Applicant:: Date: