



EMPLOYERS ASSOCIATION OF MONTANA -- ASSOCIATION GROUP PLAN



ANCILLARY BENEFIT PLANS - - EMPLOYER ELECTION FORM

Group Name			Name of Group Contact		
Physical Address			Mailing Address <i>-if different than physical</i>		
City State Zip			City State Zip		
Business Entity Type			SIC Description		
Effective Date of Coverage			Group Contact Email Address (REQUIRED)		
			Telephone		
			Tax Identification Number		
			SIC Code		

BENEFIT OPTIONS

<input type="checkbox"/> Required	\$10,000 Term Life and AD&D with UNUM paid for by the employer at \$1.98 per employee per month. Which includes the following additional benefits: <input checked="" type="checkbox"/> Travel Assistance with assist america® <input checked="" type="checkbox"/> Employee Assistance Program with Ceridian®
<input type="checkbox"/> Required	Voluntary Benefits with the UNUM Call Center for Beneficiary Designations (new and updated) on the Basic Term Life. Enrollment in Voluntary Term Life for Employee Only Enrollment in Voluntary Whole Life Enrollment in Voluntary Accident
<input type="checkbox"/> YES <input type="checkbox"/> NO	Dependent Term Life with UNUM (\$10,000 Spouse / \$5,000 Child) at \$2.29 per family unit <input type="checkbox"/> Employer Funded <input type="checkbox"/> Employee Paid
<input type="checkbox"/> YES <input type="checkbox"/> NO	Dental coverage with Delta Dental (Plan includes: exams, x-rays, and cleanings sponsored by the employer and the employees can elect additional coverage.)
<input type="checkbox"/> YES <input type="checkbox"/> NO	NEW!! Vision coverage with VSP (Plan includes: exams and materials with a small co-pay) Employer Contribution: _____% Employee Contribution: _____% Eligibility Wait Period: New employees will be eligible 1 st of the month following _____ days of continuous employment.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Flex Plan(s) with FlexCONNECT <input type="checkbox"/> Premium Only Plan <input type="checkbox"/> Full Flex Plan <input type="checkbox"/> HRA / MERP Plan <input type="checkbox"/> HSA Plan
<input type="checkbox"/> YES <input type="checkbox"/> NO	COBRA (all products with ICMI) at a rate of \$1.65 per employee per month
<input type="checkbox"/> Required	Combined Billing for all above plans at \$0.25 per employee per month.

I certify that all information provided by me to complete this application is true.

Printed Name of Group Leader	Title of Group Leader	Representative Name
Signature of Group Leader or Authorized Signer	Date	Representative No.