GROUP HEALTH INSURANCE EMPLOYER ELECTION FORM

Montana Food Distributors Association

Underwritten By

ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC.
2806 S. GARFIELD STREET
P.O. BOX 3507
MISSOULA, MT 59806-3507
(406) 523-3122
1-800-340-6805

Group Health Insurance
Employer Election Form

Section 1: Employer Information (Complete all information)		
Company Name:	Nature of Business:	
Mailing Address:		
City:	State:	Zip Code:
Is Your Company Registered with the Montana Secretary of State? ❑ Yes ❑ No		

Section 2: Participation	
What is the employer contribution toward employee premium?	❑ 100% ❑ 75% ❑ 50% ❑ Other (cannot be less than 50%)_______
Is there a different criterion by class of employee? If so, identify what constitutes a class and how contribution is determined. ❑ Yes ❑ No If yes, ____	
What is the employer contribution toward dependent premium?	❑ 100% ❑ 75% ❑ 50% ❑ 25% ❑ 0% ❑ Other ____
What is the Waiting Period* for new employees *To satisfy the Waiting Period(s), an eligible employee must be employed by the employer and actively at work for the number of hours per month required for eligibility, without break in active employment, for the entire Waiting Period.	First day of the month following: ❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days
What is the total number of employees (include employees who have waived insurance) as of effective date? _________	
What is the total number of employees eligible for coverage under this Policy? ______ If the Employer pays 100% of the Employee premium, all eligible employees (100% of eligible employees) must be covered, except those who have waived coverage as a result of other health coverage or for qualified religious reasons. If the Employer pays less than 100% of the Employee premium, 75% of eligible employees must be covered.	

____
Initials (Employer)

Section 3: COBRA Continuation Coverage

Some employers may be required to provide COBRA continuation coverage for employees and their covered dependents. An Employer is exempt from federal COBRA continuation coverage requirements if the Employer employed less than 20 employees for 50% or more of its regular work days for the calendar year immediately before the current calendar year. Employees means all common law employees (full-time and part-time and leased) as defined by Section 414(n) of the Internal Revenue Code.

Is the undersigned Employer required to provide COBRA continuation coverage? ❑ Yes ❑ No

If your group is COBRA-eligible, will COBRA participants be covered under the AL&H Policy? ❑ Yes ❑ No
If yes, number of COBRA participants enrolling? ________

The Employer will be required to re-verify COBRA continuation coverage status on an annual basis and AL&H is entitled to perform payroll and other audits from time to time to verify this status.

Section 4: Employer Statement

The undersigned employer acknowledges that he or she has read and completed this Employer Election Form, including the attached Outline of Coverage and Schedule of Medical Benefits, which is a part of this Form. The undersigned employer has initialed each page of the Outline of Coverage and Schedule of Medical Benefits, which initials indicate that the undersigned understands and agrees with the selections and benefits indicated in this Form.

___________________________________	_______________________________
Printed Name	Title
___________________________________	_______________________________
Signature	Date

____
Initials (Employer)