



**CHOICES: THE MONTANA UNIVERSITY SYSTEM'S
FLEXIBLE BENEFIT PROGRAM
MONTANA UNIVERSITY SYSTEM**

**FLEXCONNECT CLAIMS ROLLOVER
ELECTION TO PARTICIPATE
*(for Blue Cross/Blue Shield Participants Only)***

Employee Name: _____

Employee Mailing Address: _____

Employee Social Security number: _____

Campus Name: _____

As a participant in the Montana University System Flexible Benefit Program and their BlueCross/BlueShield of Montana group health insurance coverage, I understand that I have the opportunity to participate in ***FlexConnect Claims Rollover*** and acknowledge that I have received and understand the following *Authorization for Use of an Individual's Health Information*.

OPTIONAL: I elect to participate in the FlexConnect Claims Rollover on my own behalf and as a parent or other personal representative of the following individual(s) who are under the age of 18 years:

NOTE: ALL COVERED INDIVIDUALS AGE 18 YEARS OR OLDER MUST SIGN THIS FORM AND MUST BE CLAIMED AS A DEPENDENT ON THE PARTICIPANT'S TAX RETURN. SIGNING BELOW INDICATES THAT THE INDIVIDUAL HAS READ AND UNDERSTANDS THE FLEXCONNECT CLAIMS ROLLOVER AUTHORIZATION SECTION OF THIS FORM (PAGE 2).

Printed Name	Signature	Relationship	Age

Validity of Authorization: Under applicable law, this authorization is valid for no longer than 24 months. Please specify the length of time you wish to authorize this use.

- 24 months from the date of signature; or
- Until _____ (specify, but no longer than 24 months from date of signature).

Mail Form to: FlexConnect, P.O. Box 2019, Helena, MT 59624-2019