Monica J. Lindeen
CSI | Insure Montana
Montana Commissioner of Securities & Insurance

EMPLOYEE ASSISTANCE OPT-IN FORM

Complete and return to: 840 Helena Avenue
Helena, MT 59601
Fax: 406-444-3435
Telephone: 406-444-2040
Toll Free: 800-332-6148

By completing this form, employees consent to have their premium assistance payments issued through direct deposit by electronic fund transfer to their employer's bank account listed below:

Business Name:_____

Employer Bank Information: ATTACH A VOIDED CHECK TO THIS FORM. (Do not send deposit slips)
Name on Account: _____
Transit Routing Number (9 digits): _____
Bank Account Number (include zeros, do not include check number): _____
Type of Account (select only one): ____ Checking ___ Savings
Date Bank Account Opened: _____/_____/_____
Financial Institution Name: _____
Bank Address: _____
City: _____ State: _____ Zip: _____
Bank Phone Number: _____ Ext: _____

Business Owner:_____

By accepting the employees' Insure Montana premium assistance payments, I agree to apply this payment to the employees' health insurance premiums by reducing their payroll deduction amounts.

Signature: _____ Date:_____

Deposit my premium assistance payments directly into my employer's account. I acknowledge that, at the discretion of Insure Montana Program, I am obligated to repay to the Insure Montana Program the amount of any overpayment I receive due to incorrectly calculated subsidy amounts. I recognize that this obligation applies even though the premium assistance payments will be issued to my employer.

Employee Name (print name):
Employee Signature: Date:
Employee Name (print name):
Employee Signature: Date:
Employee Name (print name)
Employee Signature: Date:
Employee Name (print name):
Employee Signature: Date:

This agreement can be nullified by notifying Insure Montana in writing that you no longer want to Opt-In. All changes will take effect on the next scheduled payment.