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

EMPLOYEE PREMIUM ASSISTANCE APPLICATION

Complete and return to: 840 Helena Ave
Helena, MT 59601
Phone: 1-800-332-6148
Fax: 406-444-3435
insuremt@mt.gov

Instructions: The ELIGIBLE EMPLOYEE must complete and sign this two-page application. It must be submitted with a change report form within 30 days from the date the employee was added to the health insurance plan. Failure to complete and submit this application within 30 days will delay initiation of premium incentive and assistance payments for this employee. Late applications will be processed effective the month following the date the application is received. No retroactive payments will be made for payments missed due to late application submissions. A completed W-9 form (page 3) and verification of household income must be submitted with this application. If you have questions, please contact the Insure Montana staff at the numbers listed above.

EMPLOYEE DEMOGRAPHIC INFORMATION (all fields required)

Business Name	Date Employee is enrolled in the Health Insurance (mm/dd/yyyy)	Are you an owner of the business? Y or N	
First Name	M/I	Last Name	
Social Security Number	Gender M/F	Date of Birth	Tobacco User? Y or N
Home/Cell Number	Work Number	Email Address	
Physical Address	City/State/Zip		
Mailing Address	City/State/Zip		

HOUSEHOLD MEMBERS (required)

List all family members and dependents of the participating employee who live in the home more than 50% of the time. Include adult dependents (and their family members if applicable) not living in the home but enrolled in the employee's health plan.

Name (First, M/I, Last)	Gender M/F	Relationship to Employee	Social Security Number	Date of Birth (mm/dd/yyyy)	Enrolled in the Health Insurance?	Tobacco User (18 and older) Y or N	Zip Code Of spouse/dependent

HOUSEHOLD INCOME (required)

List total annual gross household income (before taxes) from all sources, including: wages, Social Security or disability benefits, worker's compensation, unemployment, distributions, etc. Provide verification of all household members' income. Acceptable forms of verification may include the most recent federal tax return Form 1040, wage stubs, W-2 forms, etc.

Annual gross household income is $

PAYMENT INFORMATION

(Select ONE)

□ **I elect to receive a paper check for my monthly premium assistance payment.**

□ **Bank Account Opt-In –** By opting-in, I am agreeing to have my employee premium assistance payments deposited into my employer's bank account, and therefore I agree to allow my employer to learn the amount of the premium assistance subsidy I receive each month. 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. **Initials** _____

□ **Electronic Funds Transfer**

Information collected will be used for Electronic Funds Transfer (EFT) to deposit your monthly premium assistance amount. **Please include a voided check with this form.** If a voided check is not available, attach a letter from your financial institution indicating the bank transit routing and account numbers. The document must be on bank letterhead and signed by a bank official.

□ Checking □ Savings - include a voided check or letter from your financial institution with bank routing number and account number

Do you want to receive your Electronic Funds Transfer receipt by email to the address listed above? □ Yes □ No

By selecting "No", no receipt of payment will be issued.

CERTIFICATION AND SIGNATURE

Unsigned applications are considered incomplete. Please read the following information and sign below:

I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information may include criminal prosecution (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.

I understand that premium assistance payments are issued to me because I have a personal out of pocket expense for my monthly health insurance premiums.

□ I have attached verification of all household members' annual income.

□ I have completed and signed a W-9 form (page 3).

Employee Signature _____ **Date** _____

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required):
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ►

☐ Other (see instructions) ►

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

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INCOME VERIFICATION FORM

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

Income Verification Form

Business Name	
Employee Name	
Date employment began	
Hours per week	Pay per hour
Wages per week if not paid per hour	
How often paid	

Provide verification of <u>all</u> household members' income. Acceptable forms of verification may include the most recent federal tax return Form 1040, wage stubs, W-2 forms, etc.

Unsigned forms are considered incomplete. Please read the following information:

I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information may include criminal prosecution (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.

Employee Signature	Date
Employer Signature	Date