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

PURCHASING POOL CHANGE REPORT FORM

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

Employee Name

Business Name	Insurance Agent Name

TYPE OF CHANGE

□ New Employee ESTIMATE QUOTE ONLY (attach Premium Assistance application and household income verification)

□ New Employee (attach Premium Assistance application and household income verification)	Date Employee enrolled in health insurance? (mm/dd/yyyy)

□ Delete Employee and all dependents as of this date : (mm/dd/yyyy)

□ Delete Spouse as of this date (mm/dd/yyyy)

□ Add Spouse as of this date (mm/dd/yyyy)
(provide Name, Date of Birth, and Social Security Number)

□ Add dependent(s) as of this date (mm/dd/yyyy)
(provide name(s), date(s) of birth, and Social Security Number(s)

□ Delete dependent(s) as of this day (mm/dd/yyyy) Name(s)

Are the dependent(s) being removed due to eligibility for -

- Healthy Montana Kids (formerly known as CHIP)? □ Yes □ No
- Healthy Montana Kids *Plus* (formerly known as Medicaid)? □ Yes □ No

□ Other (please explain)

□ Household Income Change – Indicate the applicable household income level below

HOUSEHOLD INCOME

List total household gross (before taxes) annual income from all sources, including: wages, Social Security or disability benefits, worker's compensation, distributions, unemployment, etc.

Single:	**Married (no children):**	**Single with children:**	**Family (married with children):**
___Less than $9,570	___Less than $12,830	___Less than $16,090	___ less than $19,350
___$9,571 –$ 14,355	___$12,831 –$ 19,245	___$16,091- $24,135	___$19,351- $29,025
___$14,356 – $19,140	___$19,246 – $25,660	___$24,136- $32,180	___$29,026- $38,700
___$19,141 – $23,925	___$25,661 – $32,075	___$32,181- $40,225	___$38,701- $48,375
___$23,926-$28,710	___$32,076 - $38,490	___$40,226- $48,270	___$48,376- $58,050
___$28,711 and over	___$38,491 and over	___$48,271 and over	___$58,051 and over

CERTIFICATION AND SIGNATURE

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 which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this form if requested. I understand that State staff may obtain documents and/or information to verify statements on this form. 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.

Signature **Date**