CAFETERIA BENEFITS SELECTION FORM FOR **RETIREES**

1. Choose one ONLY from Option 1 or Option 2; only ONE from Dental Plan Option; only ONE from Vision Plan Option.
2. Complete personal information, then sign and date the form.
3. Return the form by emailing it to insurance@helenaschools.org or by delivering/mailing it to:
   Lincoln Center, Attn HR, 1325 Poplar Street, Helena MT 59601

HEALTH INSURANCE OPTION 1 WITH RX

PLAN PARTICIPANT(S)	CHECK ONE	MONTHLY PREMIUM
Retiree Only		$1,155.31
Retiree + Spouse		$2,216.17
Retiree + Child		$1,450.38
Retiree + Children		$1,566.39
Retiree + Family (1 Child)		$2,506.24
Retiree + Family Children		$2,622.28
Medicare Eligible Retiree		*$634.73

HEALTH INSURANCE OPTION 2 WITH RX

PLAN PARTICIPANT(S)	CHECK ONE	MONTHLY PREMIUM
Retiree Only		$955.06
Retiree + Spouse		$1,824.19
Retiree + Child		$1,193.84
Retiree + Children		$1,289.35
Retiree + Family (1 Child)		$2,062.95
Retiree + Family Children		$2,158.47
Medicare Eligible Retiree		*$428.58

DENTAL PLAN OPTION

PLAN PARTICIPANT(S)	CHECK ONE	MONTHLY PREMIUM
Retiree Only		$53.29
Retiree + Spouse		$101.78
Retiree + Child		$66.61
Retiree + Children		$71.94
Retiree + Family (1 Child)		$115.10
Retiree + Family Children		$120.43

VISION PLAN OPTION

PLAN PARTICIPANT(S)	CHECK ONE	MONTHLY PREMIUM
Retiree Only		$13.55
Retiree + Spouse		$25.88

** The Medicare rate for Health Insurance Option 1 or Health Insurance Option 2 does not cover does not cover pharmacy. Retirees will need to enroll in Medicare Part D or other coverage for pharmacy.*

The Plan Year begins October 1, 2026 and runs through September 30, 2027.

FULL LEGAL NAME:	
EMAIL ADDRESS:	**PHONE #:**
MAILING ADDRESS:	
CITY, STATE, ZIP CODE:	

YOUR SIGNATURE *REQUIRED*	DATE
HR DIRECTOR/DESIGNEE *VERIFIED*	DATE

Support: insurance@helenaschools.org or 406-324-2014

CAFETERIA BENEFITS SELECTION FORM FOR **RETIREES**

Additional Participant Information – Plan Year October 1, 2026 through September 30, 2027.

Complete this page if the coverage selected on Page 1 includes a spouse, child, children, or family. List the legal name and requested information for each dependent to be enrolled.

SPOUSE INFORMATION	
FULL LEGAL NAME:	**DATE OF BIRTH:**

CHILD/DEPENDENT INFORMATION			
#	**CHILD/DEPENDENT FULL LEGAL NAME**	**DATE OF BIRTH**	**RELATIONSHIP**
1			
2			
3			
4			
5			
6			
7			
8			

COVERAGE SELECTION REFERENCE
Dependent information is needed for Retiree + Spouse, Retiree + Child, Retiree + Children, Retiree + Family (1 Child), and Retiree + Family Children selections on Page 1. For vision, dependent information is needed for Retiree + Spouse.

ADDITIONAL NOTES/SPECIAL INSTRUCTIONS

RETIREE SIGNATURE *REQUIRED*	DATE

Support: insurance@helenaschools.org or 406-324-2014