BlueCross BlueShield of Montana

Montana Supplemental Employment Verification

To be used with the UI5 report or other proof of wages documentation

Employer's Name _____ SIC Code _____

Employer's Address _____ City _____ State _____ ZIP Code _____

- Proof-of-wages documentation is required when enrolling new small groups. We encourage employers to submit the most recent quarterly Wage and Tax Report (commonly referred to as the UI5 report). If a current UI5 report is not available, we will accept other types of documentation as described in our Broker Tips guide.
- You must submit this form (Montana Supplemental Employment Verification-MSEV) when you have hired or are compensating employees other than those found on your proof-of-wages documentation.
- On your proof-of-wages documentation, please mark each employee listed with the appropriate status code from the list below.
- Additionally, the status codes below should be used on page 2 of this form.

Each full-time employee must complete an enrollment application indicating whether they are requesting or declining coverage.

STATUS CODES

F	Full-time employee who works 30 or more hours per week
P	Part-time employee who works less than 30 hours per week
I	Independent contractor
O	Owners, partners and officers
S	Seasonal employee or temporary employee
D	Totally disabled employee
C	Continued employee under state or federal law
T	Terminated employee no longer employed by the company
W	Full-time employees in waiting period

EMPLOYEES NOT LISTED ON THE UI5 REPORT OR OTHER PROOF OF WAGES DOCUMENTATION

On page 2 of this form, please list the following persons employed by you:

- New employees who work a minimum of 30 hours per week
- Owners, partners and officers
- Independent contractors
  (List only if offering coverage. It is not necessary for you to offer coverage to independent contractors; however, you must offer coverage to all independent contractors who work for you if you wish to cover any independent contractors.)
- Other
  (Please define employees who fall into this category so BCBSMT may determine if they are eligible for coverage.)

These persons must be listed even if they decline coverage.

	NAME	DATE OF FULL-TIME EMPLOYMENT	HOURS WORKED PER WEEK	STATUS CODE	APPLYING FOR COVERAGE (YES) DECLINING COVERAGE (NO) ATTACH APPLICATION
1					☐ Yes ☐ No
2					☐ Yes ☐ No
3					☐ Yes ☐ No
4					☐ Yes ☐ No
5					☐ Yes ☐ No
6					☐ Yes ☐ No
7					☐ Yes ☐ No
8					☐ Yes ☐ No
9					☐ Yes ☐ No
10					☐ Yes ☐ No
11					☐ Yes ☐ No
12					☐ Yes ☐ No
13					☐ Yes ☐ No
14					☐ Yes ☐ No
15					☐ Yes ☐ No
16					☐ Yes ☐ No
17					☐ Yes ☐ No
18					☐ Yes ☐ No
19					☐ Yes ☐ No
20					☐ Yes ☐ No
21					☐ Yes ☐ No
22					☐ Yes ☐ No
23					☐ Yes ☐ No
24					☐ Yes ☐ No
25					☐ Yes ☐ No

I hereby certify that I have read this document and that the information provided is accurate and complete. I also certify that the information provided here can be substantiated by business records maintained by me. Upon request, I agree to provide the documentation requested by BCBSMT verifying participation and eligibility requirements. I understand that providing incomplete, inaccurate or untimely information may void, reduce or terminate the group's coverage.

Signature of Authorized Company Official _____ Title _____ Date _____

Print Name of Authorized Company Official _____

Signature of Agent _____

BCBSMT reserves the right to request documents verifying the above information. In addition, it reserves the right to reverify employment information at any time during the course of your contract with BCBSMT.