

**MONTANA UNIVERSITY SYSTEM
 DEPENDENT PREMIUM HARDSHIP APPLICATION**

Please answer each question below. Partially completed applications will be returned.

Name:	Date of Birth:	
Mailing Address:		
City:	State:	ZIP Code:
Contact telephone number:	E-mail:	
Policyholder's full name:		
ID#:		

FAMILY INFORMATION

Have you applied for coverage for dependent children through Healthy Montana Kids Program (HMK)? YES NO

If you applied and were denied coverage, please enclose a copy of the denial letter.

If your answer is NO, are the dependent children over age 19, but under age 26?
 YES NO

(Application to HMK is required for children aged 0 to 19, before a hardship application can be considered)

How many dependent children do you have?

What is your household size (total number of people living in your home)?

FINANCIAL INFORMATION

Do any family members have special needs, either medical or financial? YES NO

If any, please describe the needs.

What is your total household income (before taxes)? Please include all sources of income.

Please describe in detail the hardship incurred that supports this application:

Policyholder's signature: _____
 Date: _____