



**Enrollment Form**

The Montana State Fund (MSF) and the State Fund Agricultural Group (SFAG) have entered into an agreement to provide a group plan to qualifying group members. To participate in the group plan, a group member must complete and sign this form.

**General Provisions**

If required, each member must meet eligibility requirements to participate in the group plan. The criteria may include the class codes that qualify, eligible loss ratio and/or experience modification factors. The effective date of the policy must be within the group plan year. This form must be received by MSF within 90 days of the effective date of the policy to be considered for participation in the group plan.

**Participating members shall:**

1. Maintain a policy with MSF and be subject to the terms of the policy.
2. Participate in the loss control program by attending a safety workshop, seminar, meeting or conference, participate in on-site safety visit(s) or receipt of newsletters, periodic bulletins and other safety information, materials or publications.
3. Maintain an association membership in good standing.

**The SFAG shall:**

Assist MSF with the operation of the group plan.

**MSF shall:**

Retain responsibility for underwriting, policy cancellation, claims management and claims related process.

**Release**

By signing this form, I authorize MSF to release to SFAG (for internal use only) premium, loss and other data on my policy.

**Termination**

1. MSF may terminate a member's participation in this group plan if the member does not maintain an association membership in good standing, is in default of an obligation to MSF or fails to meet minimum eligibility requirements in future years (if applicable).
2. MSF may terminate a member's participation by serving notice in writing to all affected parties. Termination is effective the date specified in the notice. If no date is specified in the notice, the date of the written notice is the termination date.
3. Members may terminate their participation by serving notice in writing to the MSF. Termination is effective the date of the written notice.

**Effective Date**

If the form is received by MSF within 90 days of the effective date of the policy and within the contract year and the policy qualifies, participation in the group plan shall start on the effective date of the policy.

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Insured Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City State Zip: \_\_\_\_\_

Insured Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insured Phone: \_\_\_\_\_ Insured Email: \_\_\_\_\_

I am a member of:

- |  |  |
|--|--|
| <input type="checkbox"/> Montana Farm Bureau Federation    | <input type="checkbox"/> Montana Pork Producers Council  |
| <input type="checkbox"/> Montana Stockgrowers Association  | <input type="checkbox"/> Montana Cattlemen's Association |
| <input type="checkbox"/> Montana Wool Growers Association  | <input type="checkbox"/> Montana Organics Association    |
| <input type="checkbox"/> Montana Grain Growers Association |  |

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Return completed form to: Montana State Fund PO Box 4759 Helena, MT 59604-4759 Fax # (406) 495-5020