Lewis County

Medical & Rx Benefits Election Form

Lewis County is offering three health plans this election period. Please make your selections below, and sign and return this form to Human Resources. Remember to refer to the Benefit Guide, Educational Video(s), and In-Person Education sessions to help you select the plan that is right for you.

You can also make elections online via Employee Navigator, beginning 11/17/25.

If you do not wish to participate in a plan, please check the box marked "waive," sign and return the form to Human Resources.

Last Name, First Name, M.I.					
Phone Number					
Home Address					
City, State, Zip Code					
Preferred Email					
Birthdate		**Social Security Number (SSN)**		**Sex**	M / F
Other Medical Coverage?	**YES / NO**	**If "YES", provide Effective Dates, name & policy number of insurance carrier, HMO, or other sources & your Member Identification Number**			

Medical / Rx Insurance

I choose the following health insurance coverage:

- ☐ Aetna POS $500 Medical Plan
- ☐ Aetna POS $1000 Medical Plan
- ☐ Aetna HSA / HDHP $2000 Medical Plan
- ☐ Waive: I choose not to participate in any health plan.

Please choose one of the following coverage categories:

- ☐ Employee Only
- ☐ Employee + Spouse / Domestic Partner Family
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Waive: I choose not to participate in any health plan.

Spouse / Domestic Partner Name – Last, First M.I.	**SSN**	**Sex** M / F	**Birthdate**
Child Name – Last, First M.I.	**SSN**	**Sex** M / F	**Birthdate**
Child Name – Last, First M.I.	**SSN**	**Sex** M / F	**Birthdate**
Child Name – Last, First M.I.	**SSN**	**Sex** M / F	**Birthdate**

Child Name – Last, First M.I.	SSN	Sex M / F	Birthdate
Child Name – Last, First M.I.	SSN	Sex M / F	Birthdate
Child Name – Last, First M.I.	SSN	Sex M / F	Birthdate
Child Name – Last, First M.I.	SSN	Sex M / F	Birthdate
Child Name – Last, First M.I.	SSN	Sex M / F	Birthdate
Child Name – Last, First M.I.	SSN	Sex M / F	Birthdate

Does any dependent listed live at a different address than the employees? ☐ Yes ☐ No

If "Yes", Who & what address?

Special Remarks:

Employee Signature	Date

inspira™ FINANCIAL

Health Savings Account (HSA) Employer Payroll Deduction

What you should know when completing this form:

- This form supports your request to have HSA contributions deducted from your pay by your employer
- You may use this form to authorize either a one-time transaction or periodic transfer
- You'll need to keep a copy of the completed form for your files
- You'll need to submit the completed form directly to your employer

Account Holder Information

Name : Last	First	MI

Birthdate (MM/DD/YYYY)	Social Security Number	Telephone Number	Email Address
/ /	- -	( ) -	

Street Address (Don't use a PO Box Address)

City	State	ZIP Code	Country

Employer Name

Lewis County

Payroll Deduction

Check the box that applies to you and specify a dollar amount:

☐ **Lump sum:** I wish to authorize a ***one time*** contribution to my HSA in the amount of $ _____.

☐ **Periodic deduction:** I wish to authorize a periodic contribution to my HSA.
I choose this period: ☐ weekly ☐ bi-weekly ☐ semi-monthly or ☐ monthly for this amount: $ _____.

Authorization

I authorize my employer to deduct the amount(s) above from my pay. My employer will remit such amount(s) to my HSA administrator or its designee for deposit into my HSA. I know my employer will establish the timing of contributions.

If I have authorized periodic deductions, I know I can terminate it by giving written notice to my employer. And that I must do it at least one month before the effective date of the change.

X _____	_____	_____
Signature	**Print Name**	**Date Signed**

ENROLLMENT • CHANGE FORM

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

SECTION 1: Group Customer Information *(To be Completed by the Recordkeeper)*

Name of Group Customer/Employer	Group Customer Number	Division	Class	Dept Code
Lewis County	5780810			

Date of hire *(mm/dd/yyyy)*	Coverage Effective Date *(mm/dd/yyyy)*

Original COBRA Effective Date *(if applicable, mm/dd/yyyy)*	COBRA Termination Date *(if applicable, mm/dd/yyyy)*

SECTION 2: Your Enrollment Information *(To be Completed by the Employee in blue or black ink)*

First Name	Middle Name	Last Name

SSN	Date of birth *(mm/dd/yyyy)*	Gender:	Marital status:
		☐ Male ☐ Female	☐ Single ☐ Married

Address	City	State	ZIP

Job title	Basic annual earnings $	☐ Salaried ☐ Hourly	Hours worked per week

☐ New Enrollment ☐ Change in Enrollment ☐ COBRA Continuation
If due to a Qualifying Event, enter date *(mm/dd/yyyy)*

Phone number	Email address

- I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life and AD&D. I understand that contributions are required for the benefits I select below.
- For Minnesota and Vermont State residents - If I am enrolling for Accident Insurance or Hospital Indemnity Insurance: I declare that all individuals to be insured have comprehensive medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses.
- I have received and read a copy of the Outline of Coverage or other disclosure document for the Accident Insurance, Hospital Indemnity Insurance and Critical Illness Insurance.
- In certain states, this coverage may be referred to as Critical Illness Insurance, Specified Disease Insurance, Limited Benefit Insurance or Limited Benefit Critical Illness Insurance.
- The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**
- If you are enrolling after the initial enrollment period, please refer to the Declarations and Signature section of this enrollment form to determine the evidence of insurability and late entrant requirements. If evidence of insurability is required for a coverage you are electing, you must complete a Statement of Health form for all amounts you are requesting.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF02-1 ADM** *applies to residents of Oregon;*
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF02-1
ADM *applies to residents of Connecticut, North Dakota, and Utah)*

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

☒ Basic Life[1] and AD&D (Core)
☐ Supplemental/Optional Life[1] (Buy up)
Enter amount requested $_____
☐ Supplemental/Optional Dependent Spouse/Domestic Partner[2] Life[1, 3] (Buy up)
Enter amount requested $_____
☐ Supplemental/Optional Dependent Child Life[3] (Buy up)
Enter amount requested $_____
☐ Supplemental/Optional AD&D (Buy up)
Enter amount requested $_____
☐ Supplemental/Optional Dependent Spouse/Domestic Partner[2] AD&D (Buy up)
Enter amount requested $_____
☐ Supplemental/Optional Dependent Child AD&D (Buy up)
Enter amount requested $_____

Disability Income Insurance

☐ Long Term Disability Benefits

Dental Insurance

☐ Dental Option
Select your level of coverage
☐ Employee Only
☐ Employee + Spouse/Domestic Partner[2]
☐ Employee + Child(ren)
☐ Employee + Spouse/Domestic Partner[2] + Child(ren)

Vision Insurance

☐ Vision Option
Select your level of coverage
☐ Employee Only
☐ Employee + Spouse/Domestic Partner[2]
☐ Employee + Child(ren)
☐ Employee + Spouse/Domestic Partner[2] + Child(ren)

Accident Insurance

First select your option	**Then select your level of coverage**
☐ Low Option	☐ Employee Only
☐ High Option	☐ Employee + Spouse/Domestic Partner[2]
	☐ Employee + Child(ren)
	☐ Employee + Spouse/Domestic Partner[2] + Child(ren)

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Hospital Indemnity Insurance

First select your option

- ☐ Low Option
- ☐ High Option

Then select your level of coverage

- ☐ Employee Only
- ☐ Employee + Spouse/Domestic Partner[2]
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Domestic Partner[2] + Child(ren)

Critical Illness Insurance

Select your level of coverage:

☐ Critical Illness Insurance for Employee

Benefit Amount

- ☐ $15,000
- ☐ $30,000

☐ Critical Illness Insurance for Dependent Spouse/Domestic Partner[2]

☐ Critical Illness Insurance for Dependent Child

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

[3] Amounts will be subject to state limits, if applicable.

SECTION 3: Dependent Information

If you are applying for coverages for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below.

Name of your Spouse/Domestic Partner *(first, middle, last)*	Date of birth *(mm/dd/yyyy)*	☐ Male ☐ Female
Name(s) of your Child(ren) *(first, middle, last)*	Date of birth *(mm/dd/yyyy)*	☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

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GEF02-1
ADM *applies to residents of Connecticut, North Dakota, and Utah)*

SECTION 4: Fraud Warnings

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.
Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.
Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.
Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

GEF09-1
FW
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GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.
New York (only applies to Accident and Health Insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.
Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW
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GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

SECTION 5: Beneficiary Designation for Employee Insurance

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name *(first, middle, last)*	SSN	Date of birth *(mm/dd/yyyy)*	Relationship	**Share %**
Address	City	State / ZIP	Phone number	
Full Name *(first, middle, last)*	SSN	Date of birth *(mm/dd/yyyy)*	Relationship	**Share %**
Address	City	State / ZIP	Phone number	
Full Name *(first, middle, last)*	SSN	Date of birth *(mm/dd/yyyy)*	Relationship	**Share %**
Address	City	State / ZIP	Phone number	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total: 100%

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name *(first, middle, last)*	SSN	Date of birth *(mm/dd/yyyy)*	Relationship	**Share %**
Address	City	State / ZIP	Phone number	
Full Name *(first, middle, last)*	SSN	Date of birth *(mm/dd/yyyy)*	Relationship	**Share %**
Address	City	State / ZIP	Phone number	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total: 100%

SECTION 6: Declarations and Signature

Your Accident, Hospital Indemnity and Critical Illness certificate provides limited benefits. Read your certificate carefully.

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.

GEF09-1 DEC
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2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
4. I understand that if I do not enroll for life or disability coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired. I understand that if I do not enroll for vision coverage during the initial enrollment period, I cannot enroll for such coverage until the next annual enrollment period.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
7. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
8. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here	Signature of Employee	Date signed *(mm/dd/yyyy)*
Print First Name	Print Middle Name	Print Last Name

GEF09-1 DEC
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GEF09-1 DEC *applies to residents of Connecticut, North Dakota and Utah)*

How to submit this form

After completion, make a copy for your records and return the original to your employer.

take care® Flex Benefits Plan

Enrollment Form

take care® by WageWorks

PLEASE PRINT. All information is required or your enrollment cannot be processed.

~~Employer~~ LEWIS COUNTY Social Security Number

Employee Name (First, Last)

Date of Birth (MM-DD-YYYY) Date Hired (MM-DD-YYYY)

Home (Street) Address APT.

City State Zip

Home Phone Email

By enrolling in the plan you will receive a take care® Flex Benefits Card to pay for qualified plan expenses. If you would also like to receive a Card for your spouse or dependent (age 18 years or older) you may do so by logging into your account at www.takecareWageWorks.com.

Employer to complete or enrollment cannot be processed.

Plan year start (MM/DD/YY) 01/01/26 and end 12/31/26. First payroll start date 01/10/26.

No. of Pays 24. Dept. _____.

OPTION 1 ***Health Care Account***

YES ☐ I elect to contribute $ _____ (before taxes) for the PLAN YEAR, which is $ _____ per pay period to fund my account that pays qualified out-of-pocket healthcare expenses that are not covered by my employer's health plan or any other health plan.

NO ☐ I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 2 ***Dependent Care Account***

This pays for day care expenses for a dependent child, adult or elder, so that you may work. Eligible services include: nursery school, nanny, before and after school care through age 12, day care for a disabled adult or child, elder day care for parent or dependent, day camp through age 12.

YES ☐ I elect to contribute $ _____ (before taxes) for the Plan Year, which is $ _____ per pay period to fund my account that pays qualified dependent daycare or elder care expenses.

NO ☐ I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 3 ***Agreement to Save Taxes on Insurance Premiums***

YES ☒ On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

NO ☐ I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 4 ~~***Additional Benefit*** (please insert description provided by your HR department, if applicable)~~

A $3.95 service will be assessed monthly via employee payroll deduction.

~~*YES*~~ ☐ ~~I elect to contribute $ _____ (before taxes) for the Plan Year, which is $ _____ per pay period for funding reimbursement of this additional benefit outlined by my HR department.~~

~~*NO*~~ ☐ ~~I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.~~

IMPORTANT: Please read the following before signing this enrollment form. My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read, and understand the Summary Plan Description. I understand that the take care® Card is available to pay only qualified expenses and that qualified expenses paid with the Card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the Card from any other source. I understand that when using the take care® Card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my Card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee signature _____ Date _____

Return completed form to your employer.