Medical/Rx, Dental & Vision 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.

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:

- ☐ Regence PPO $500 Medical Plan
- ☐ Regence PPO $1000 Medical Plan
- ☐ Regence 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
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Waive: I choose not to participate in any health plan.

Dental Insurance

I choose the following health insurance coverage:

- ☐ Elect Dental Coverage
- ☐ Waive: I choose not to participate in any health plan.

Please choose one of the following coverage categories:

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

Vision Insurance

I choose the following health insurance coverage:

- ☐ Elect Vision Coverage
- ☐ Waive: I choose not to participate in any health plan.

Please choose one of the following coverage categories:

- ☐ Employee Only
- ☐ Employee + Spouse / Domestic Partner

© 1999, 2012 Zywave, Inc. All rights reserved.

☐ Employee + Child(ren)
☐ Employee + Family
☐ Waive: I choose not to participate in the vision 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

© 1999, 2012 Zywave, Inc. All rights reserved.

Health Savings Account (HSA)
Employee Enrollment Form

Return completed forms to your Human Resources Department.

Employer Information

Enrollment cannot be processed without your employer's name.

Employer Name

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
Email Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP

Insurance Coverage

Insurance Carrier	
Coverage Effective Date	Coverage Type ☐ Single ☐ Family

Authorization and Certification

By opening a health savings account (HSA) with HealthEquity, you accept the terms of HSA enrollment and the custodial agreement. You may view the HSA custodial agreement here: http://resources.healthequity.com/Forms/Agreements/HealthEquity_Custodial_Agreement.pdf. Upon enrollment, you understand and agree to the following:

- You are covered by a qualified high deductible health plan (HDHP).
- You are not covered by any other non-qualified health coverage, including Medicare.
- You are not claimed as a dependent on another individual's tax return.
- HealthEquity must verify your identity in order to open your HSA.

For further information regarding HSA laws, go to http://www.irs.gov/pub/irs-pdf/p969.pdf.

Print Name	Signature	Date

FDIC

The balances in all HealthEquity HSAs are FDIC-insured unless invested in mutual funds.

Enrollment Form
United of Omaha Life Insurance Company

Mutual of Omaha Plaza, Omaha, Nebraska 68175

Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)			
*Employer Name: Lewis County		Effective Date:	Group ID: G000D3GW
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)			
*Last Name:	*First Name:		MI:
*SSN/ID Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:	E-mail Address:		
*City:	*State:	*Zip Code:	Telephone: ( ) -

Voluntary Long-Term Disability Coverage Election				
Employee Coverage Only	**Enroll**	**Decline**	**Benefit Amount**	**Premium Amount**
Voluntary Long-Term Disability	☐	☐	_____ per Month	$_____

Voluntary Critical Illness/Specified Disease Coverage Election		
Employee and Dependent Coverage	**Benefit Amount - Select One Option**	**Premium Amount**
Voluntary Critical Illness/Specified Disease - Employee	☐ $5,000 ☐ $15,000 ☐ $25,000 ☐ $30,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Critical Illness/Specified Disease - Spouse	☐ $5,000 ☐ $30,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____

The following applies to Voluntary Critical Illness/Specified Disease coverage:
- You must elect coverage for yourself for your dependent(s) to be eligible.
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.
- Child(ren) are automatically enrolled for 25% of your elected benefit amount, for no additional charge.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Health Insurance Information for Critical Illness Insurance Only			
	Employee	**Spouse**	**Child(ren)**
For Residents of CA only: Does each person proposed for insurance have an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans? (Any person without such comprehensive coverage is ineligible for this insurance.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Voluntary Accident Coverage Election

Important eligibility information for California Residents: To be eligible for Accident insurance, you the employee and your dependent(s), if applicable, must have major medical insurance, or a combination of basic hospital and basic medical insurance. Any person that does not have such insurance is ineligible for and should not elect this coverage.

Employee and Dependent Coverage	Plan Option (Choose Option 1 or Option 2)		Premium Amount	
	Option 1	Option 2	Option 1	Option 2
Voluntary Accident - Employee Only	☐	☐	$_____	$_____
Voluntary Accident - Employee + Spouse	☐	☐	$_____	$_____
Voluntary Accident - Employee + Child(ren)	☐	☐	$_____	$_____
Voluntary Accident - Employee + Family	☐	☐	$_____	$_____
	☐ Decline			

The following applies to Voluntary Accident coverage:
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Health Insurance Information for Accident Insurance Only	Employee	Spouse	Child(ren)
For Residents of CA Only: Does each person proposed for insurance have an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans? (Any person without such comprehensive coverage is ineligible for this insurance.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Voluntary Hospital Indemnity Coverage Election

IMPORTANT: This is a fixed indemnity policy, NOT health insurance. This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care. The payment you get isn't based on the size of your medical bill. There might be a limit on how much this policy will pay each year. This policy isn't a substitute for comprehensive health insurance. Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance. **Looking for comprehensive health insurance? Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options. To find out if you can get health insurance through your job, or a family member's job, contact the employer. **Questions about this policy?** For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments." If you have this policy through your job, or a family member's job, contact the employer.

Health Insurance Information for Hospital Indemnity Insurance Only	Employee	Spouse	Child(ren)
For Residents of CA Only: Does each person proposed for insurance have an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans? (Any person without such comprehensive coverage is ineligible for this insurance.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee and Dependent Coverage	Plan Option (Choose Option 1 or Option 2)		Premium Amount	
	Opt 1	Opt 2	Opt 1	Opt 2
Voluntary Hospital Indemnity - Employee Only	☐	☐	$_____	$_____
Voluntary Hospital Indemnity - Employee + Spouse/Domestic Partner	☐	☐	$_____	$_____
Voluntary Hospital Indemnity - Employee + Child(ren)	☐	☐	$_____	$_____
Voluntary Hospital Indemnity - Employee + Family	☐	☐	$_____	$_____
	☐ Decline			

The following applies to Voluntary Hospital Indemnity coverage:
- Your dependent child(ren) must be under age 26, unless the child is incapacitated.

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Premium Amount
Voluntary Life and AD&D - Employee	☐ $10,000	$_____
	☐ $30,000	$_____
	☐ $110,000	$_____
	☐ $160,000	$_____
	☐ $250,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life and AD&D - Spouse	☐ $5,000	$_____
	☐ $10,000	$_____
	☐ $15,000	$_____
	☐ $25,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life and AD&D - Child(ren)	☐ $10,000 (per child)	$_____
	☐ Other $_____	$_____
	☐ Decline	

You must complete and submit an Evidence of Insurability form if you or your spouse are enrolling for Voluntary Term Life coverage in excess of the Guaranteed Issue Amount (GIA). The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/eoi. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $25,000.
- You must elect coverage for yourself for your dependent(s) to be eligible.
- The benefit amount elected for your child(ren) cannot be more than 100% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the applicable policy as well as your age and/or salary on the effective date of the coverage.

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage. I understand and agree that insurance coverage for my eligible dependents(s) may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable policy, and that a waiting period may apply.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

Additional Information
Fraud Warning: 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. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*
Washington Fraud Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.