ELECTION FORM

Lincoln County **08/01/2018 through 7/30/2019**

Health Insurance – Joint Powers Trust

The County pays the cost of the premiums for all employees and their covered family members.

☐ **CMM $2000/$6000 70/30, $20 Office Visit Copay for first five visits**

_____Employee _____Employee + Spouse _____Employee + Child(ren) _____Family

☐ **HSA High Deductible Health Plan $3500/$3500 with PassThru Rx**

_____Employee _____Employee + Spouse _____Employee + Child(ren) _____Family

☐ **Waiver Health Insurance Coverage**

Voluntary Dental Insurance – Joint Powers Trust

☐ Yes _____Employee _____Employee + Spouse _____Employee + Child(ren) _____Family

$36.53 $73.07 $76.73 $109.61

☐ No (Waive Dental Coverage)

Voluntary Vision Insurance – Vision Service Plan: *Buy-up must mirror medical enrollment*

☐ Yes ____Employee ____Employee+Spouse ____Employee+Child(ren) ____Family

$5.55 $13.30 $14.41 $24.58

☐ No (Waive Vision Coverage)

**If enrolling or making changes to current medical, dental or vision coverage you must complete the EBMS Enrollment form*

Name (Please Print) _____

Signature _____ Date _____