ebms
The Benefit of Balance

P.O. Box 21367 Billings, MT 59104-1367
Phone: 800.777.3575 or 406.245.3575
Website: www.ebms.com

Company Name:	Group #:	Cert#:

This Section Is To Be Completed By Employee

Last Name	First Name	M.I.	Gender	Marital Status ☐ Single-S ☐ Married-M ☐ Divorced-D ☐ Legally Separated
SSN:	Date of Birth:		Email Address:	

Current Mailing Address: City: State: Zip:

Home Phone ( ) Work Phone ( ) (ext)

Life Insurance Beneficiary (if applicable):	Relationship	Contingent Life Beneficiary (if applicable)	Relationship
Address:	SSN:	Address:	SSN:

Please Indicate the Coverage Elected for Each Dependent:

List of Eligible Dependents Full Name	Social Security # Required	Gender	Date of Birth	Relationship to Employee	Medical	Dental	**Vision**
				SELF			

Other Health Benefit Information

Are you or any of your dependents enrolled in another health benefit plan? ☐ Yes If yes, please indicate other insurance coverage below.

Are any of your dependent children eligible for other Employer Sponsored Coverage ☐ No ☐ Yes If yes, please indicate other insurance coverage (OIC) below.

If other insurance coverage (OIC) information is not indicated on this enrollment form, this will imply that no other insurance coverage (OIC) is in effect and/or that no dependent children are eligible for other Employer Sponsored Coverage.

Last Name	First Name	Other Health Benefit Name, Policy Number and Phone Number:	Medicare A	Medicare B	Medical	Dental	Vision

For the Other Insurance Coverage, please complete the following. For more than one insurance continue on the back of this form.

Other Policy Holder's name: Other Policy Holder's Date of Birth: / /

Type of Policy: ☐ Employer Sponsored ☐ Retiree ☐ COBRA ☐ Individual ☐ Medicaid/CHIP/Other State Program

Relationship of Policy Holder to those covered: Effective Date of Policy: / /

Application is made for benefits under Employer's benefit plan for which I am eligible and authorization is granted to deduct from my salary or wages any premiums required. By signing below I am indicating that, to the best of my knowledge, all information is true and accurate. I understand that if the information provided herein is determined to be inaccurate, this will be considered an intentional misrepresentation and coverage could be terminated retroactively.

Accept: If you accept coverage please sign and date below. (This form is valid only if signed and dated.)

Signature Date / /

WAIVER OF PARTICIPATION: By my signature below, I acknowledge that coverage has been offered to me and I elect not to participate at this time.

Signature Date / /

This Section Is To Be Completed By Employer

Division Name:_____ Division #:_____ PPO _____ Date of Hire _____

Effective Date: _____ Plan: _____ Employment Status: ☐ Full-Time ☐ Part-Time

Occupation: _____ Earnings: $_____ Life Insurance (if applicable) $ _____

☐ Initially Eligible ☐ Open Enrollment ☐ Late Enrollment ☐ Reinstatement – Date / / ☐ Newborn ☐ Deletion ☐ Marriage ☐ Name/Address

ELECTION FORM

Lincoln County **08/01/2022 through 7/30/2023**

Health Insurance – Joint Powers Trust

The County pays 100% 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
$642.82	$1,295.42	$1,164.66	$1,818.66

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

_____Employee	_____Employee + Spouse	_____Employee + Child(ren)	_____Family
$607.21	$1,223.34	$1,099.90	$1,717.28

☐ **Waiver Health Insurance Coverage**

Voluntary Dental Insurance – Joint Powers Trust

☐ Yes

_____Employee	_____Employee + Spouse	_____Employee + Child(ren)	_____Family
$35.78	$71.58	$75.16	$107.36

☐ No (Waive Dental Coverage)

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

Name (Please Print) _____

Signature _____ Date _____