New Employee Packet

Originals must be submitted

Forms to be Completed by Employee:

1. New Employee Information sheet _____ (both sheets must be filled out)
2. New Employee Orientation Checklist _____
3. Montana New Hire Reporting Form _____
4. Form W-4 _____
5. Form I-9 _____
6. PERS Retirement Form _____
7. SRS Retirement Form _____
8. Optional PERS Retirement Form _____ (working under 960 hours)
9. Driving Record Request_____
10. Direct Deposit Authorization _____
11. Job Application _____
12. Benefit Enrollment Form _____
13. Health Insurance Election Form _____

Lincoln County Personnel Policies and Procedures:

14. Acknowledgement and receipt of Handbook Form _____
15. Appendix A: Equipment Acknowledgement Form _____
16. Appendix B: Ethics and Conflict of Interest Acknowledgement Form _____
17. Appendix C: Drug and Alcohol-Free Workplace Acknowledgement Form _____
18. Appendix D: Computers, Internet, and Email Policy Acknowledgement Form _____
19. Appendix E: Drug Testing Acknowledgement Form _____
20. Appendix F: Decedent's Warrant or Paycheck Designation Form _____

LINCOLN COUNTY
NEW EMPLOYEE PAYROLL INFORMATION SHEET
(To be completed by Human Resources Office)

1. Name: _____

2. Department: _____
   Fund Dept. Acct. Obj.

3. Job Title/Position: _____

4. Beginning Salary: _____ after 6 Months _____

5. Starting Date: _____ Workers Comp Class Code: _____

6. Classification:
   - Regular Full-time _____
   - Regular Part-time _____
   - Temporary (90 day Maximum) _____
   - Intermittent/On-call _____
   - Seasonal _____ From___/___/___To____/___/___
     (Dates)

7. Hours per week regularly scheduled to work: _____

8. Date eligible to use sick leave: _____
   (90 calendar days from beginning date of employment)

9. Date eligible to use vacation leave: _____
   (6 months from beginning date of employment)

10. Probationary period ends: _____
    (6 months from beginning date of employment)

11. Health Insurance Eligible: ☐ Yes ☐ No
    _____Date of Eligibility (within 90 days of employment)
    (Must be scheduled to work permanently at least 20 hours per week. Less than full-time employment requires employee contribution)

12. P.E.R.S. Eligible: ☐ Yes ☐ No
    (Anyone scheduled to work over 960 hours per year must contribute.)

13. S.R.S Eligible: ☐ Yes ☐ No

14. Job Application/Resume (date stamped by Job Service) _____

LINCOLN COUNTY
NEW EMPLOYEE PAYROLL INFORMATION SHEET

1. Name: _____
2. Address: _____
3. Home #: _____ Cell #: _____
4. E-Mail: _____
5. Social Security #: _____
6. Race:
   - Asian: _____
   - Black: _____
   - Hispanic: _____
   - American Indian: _____
   - Other: _____
   - Unspecified: _____
   - White: _____
7. Marital Status:
   - Married: _____
   - Single: _____
8. Birthdate: _____

NEW EMPLOYEE ORIENTATION CHECKLIST

Employee: _____ Supervisor: _____
Department: _____ Position: _____
Start Date: _____

THE FOLLOWING ITEMS SHOULD BE COVERED WITH THE EMPLOYEE WITHIN THE FIRST WEEK OF EMPLOYMENT:

1. Introduction to Co-workers/Tour of Facilities _____
2. Worker's Compensation Policy _____
3. Copy & Review of Personnel Policy Manual including: _____
    a. Overtime and Comp time Policy _____
    b. Sick and Vacation Pay _____
    c. Grievance Policy _____
    d. Health Insurance _____
    e. Probationary Period _____
    f. Travel (standard IRS rate) _____
4. Job Responsibilities _____
5. Work Hours/Lunch/Breaks _____
6. Facility Keys _____
7. Pay Period/Payroll _____
8. Review of all County & Office Safety Policies including: _____
    a. Drug Free Work Place Policy _____
    b. Fire Drill & Evacuation Procedures _____
    c. Vehicle Accidents (if applicable) _____
    d. Chemical Hazards _____
    e. Employee Safety Training _____
    f. Workplace Safety Policy _____
    g. Alcohol & Drug Testing (if applicable) _____
    h. Safety Equipment/Vehicle Operations _____
10. Parking _____
11. Picture I.D. _____

Sick Leave Eligibility _____
Vacation Leave Eligibility _____
Probationary Period Completed _____

_____ _____ _____
SUPERVISOR'S SIGNATURE EMPLOYEE SIGNATURE DATE

Distribution: Original goes to Personnel file with Payroll Clerk
Make Copies for Employee & Department Head

Montana New Hire Reporting Form

Note: All applicable information in the Employer and Employee Sections "Is Required To Be Reported"

EMPLOYER SECTION – REQUIRED INFORMATION

Federal ID Number: 81-6001387

Business Name: LINCOLN COUNTY

Mailing Address: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: 59923

Foreign Country: _____ Zip Code: _____

Business Phone: 406-283-2312 Ext. _____ Fax Number: 406-293-7057

If address changed, place X here, ☐ and make corrections below

Mailing Address: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Foreign Country: _____ Zip Code: _____

EMPLOYEE SECTION – REQUIRED INFORMATION

Social Security Number: _____ Date of Hire: _____

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Foreign Country: _____ Zip Code: _____

Home Address: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Foreign Country: _____ Zip Code: _____

Optional Employee Information

Home Phone: _____ Date of Birth: _____

Work Phone: _____ State of Hire: _____

Is Health Insurance Available: ☐ Yes ☐ No

Date Health Insurance Is Available: _____

Phone 1-888-866-0327 for New Hire Reporting Questions

Mail To: Montana New Hire Reporting,
PO Box 8013
Helena, MT 59604-8013

or **Fax to**: 1-888-272-1990 / **Local Fax**: 406-444-0745

(revised 7/2007)

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▸ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▸ **Give Form W-4 to your employer.**
▸ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		▸ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▸ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▸ $ _____

Multiply the number of other dependents by $500..... ▸ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▸ _____ **Employee's signature** (This form is not valid unless you sign it.) ▸ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $ _____

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . . **2** $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Montana Public Employee Retirement Administration
PO Box 200131 • Helena MT 59620-0131
(406) 444-3154 • Toll Free (877) 275-7372
http://mpera.mt.gov

PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS)
MEMBERSHIP/DESIGNATION OF BENEFICIARY FORM

MEMBER INFORMATION

Last Name	First Name, MI	Social Security Number*
		- -

Date of Birth	Gender	Employing Agency	Employer Number (MPERA use only)
/ /	☐ M ☐ F		

Member's Mailing Address		
City	State	Zip Code

Daytime Phone Number	Email Address
( )	

PRIMARY AND/OR CONTINGENT BENEFICIARY DESIGNATION

Completion of this section revokes all prior beneficiary designations unless you are prohibited from changing your beneficiary by a valid temporary restraining order issued pursuant to § 40-4-121, MCA. You may designate one or more primary or contingent beneficiaries by using a separate line for each person. Contingent beneficiaries receive benefits only if all listed primary beneficiaries are deceased. If you list two or more primary (or two or more contingent beneficiaries) they will be treated on a share and share alike basis. If you prefer a different allocation, please specify. If you designate a trust, a charitable organization or your estate as a primary or contingent beneficiary, you will also need to complete the "Other Designation" section.

Primary Beneficiary - *attach additional list if necessary.*

Full Name	Gender	Relationship	Birth Date	SSN*	Allocation
	☐ M ☐ F				%
	☐ M ☐ F				%
	☐ M ☐ F				%

Contingent Beneficiary (optional) - *attach additional list if necessary.*

Full Name	Gender	Relationship	Birth Date	SSN*	Allocation
	☐ M ☐ F				%
	☐ M ☐ F				%
	☐ M ☐ F				%

Other Designation (NOTE: Any designated trust must already be in existence - this form cannot create a trust. Further, by designating a trust you verify that it is (1) valid under state law; (2) irrevocable on or before your death; and (3) for the benefit of identifiable living person(s).)

Name of Trust, Charity or Estate	Trustee/Contact Name

Address	Tax Identification Number

REQUIRED SIGNATURES

Member Signature	Date

Witness Name printed (not a beneficiary)	Witness Signature	Date

Original signatures are required. MPERA cannot accept faxed or photocopies of this form.

This form must be filed with MPERA before any changes will take effect.

* For identification and tax purposes. *§19-2-403(8) MCA, 26 USC § 6109.*

Montana Public Employee Retirement Administration
PO Box 200131 • Helena MT 59620-0131
(406) 444-3154 • Toll Free (877) 275-7372
http://mpera.mt.gov

SHERIFFS' RETIREMENT SYSTEM (SRS)
MEMBERSHIP/DESIGNATION OF BENEFICIARY FORM

MEMBER INFORMATION

Last Name	First Name, MI	Social Security Number* - -
Date of Birth / / / Gender ☐ M ☐ F	Employing Agency	Employer Number (MPERA use only)
Mailing Address		
City	State	Zip Code
Daytime Phone Number ( )	Email Address	

Type Of Position (check one): ☐ Sheriff ☐ Under Sheriff ☐ Deputy Sheriff ☐ Detention Officer ☐ Gambling or Criminal Investigator

PRIMARY AND/OR CONTINGENT BENEFICIARY DESIGNATION

☐ **I wish to retain SRS beneficiary designation currently on file with MPERA.**

Completion of this section revokes all prior beneficiary designations unless you are prohibited from changing your beneficiary by a valid temporary restraining order issued pursuant to § 40-4-121, MCA. You may designate one or more primary or contingent beneficiaries by using a separate line for each person. Contingent beneficiaries receive benefits only if all listed primary beneficiaries are deceased. If you list two or more primary (or two or more contingent beneficiaries) they will be treated on a share and share alike basis. If you prefer a different allocation, please specify. If you designate a trust, a charitable organization or your estate as a primary or contingent beneficiary, you will also need to complete the "Other Designation" section.

Primary Beneficiary - *attach additional list if necessary.*

Full Name	Gender	Relationship	Birth Date	SSN*	Allocation
	☐ M ☐ F				%
	☐ M ☐ F				%
	☐ M ☐ F				%

Contingent Beneficiary (optional) - *attach additional list if necessary.*

Full Name	Gender	Relationship	Birth Date	SSN*	Allocation
	☐ M ☐ F				%
	☐ M ☐ F				%
	☐ M ☐ F				%

Other Designation (NOTE: Any designated trust must already be in existence — this form cannot create a trust; further, by your designation you verify that your trust is (1) valid under state law; (2) irrevocable on or before your death; and (3) for the benefit of identifiable living person(s).)

Name of Trust, Charity or Estate	Trustee/Contact Name
Address	Tax Identification Number

REQUIRED SIGNATURES

Member Signature		Date
Witness Name Printed (not a beneficiary)	Signature	Date

Original signatures are required. MPERA cannot accept faxed or photocopies of this form.
This form must be filed with MPERA before any changes will take effect.

* For identification and tax purposes. *§19-2-403(8) MCA, 26 USC §6109.*

Montana Public Employee Retirement Administration
PO Box 200131 • Helena MT 59620-0131
(406) 444-3154 • Toll Free (877) 275-7372

PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS)
OPTIONAL MEMBERSHIP ELECTION

This election must be completed by both employee and employer and received by MPERA within **90 days** of the employee's hire date or the employee waives membership. If any information in this form conflicts with statute or rule, the statute or rule will apply. If you have any questions about optional membership, please contact our office.

EMPLOYEE INFORMATION – to be completed by employee

Last Name	First Name, MI	Social Security Number *
Date of Birth	Email Address	Phone Number ( )

Membership is optional only for certain new employees. (See optional positions below.) If you are currently an active or inactive member of PERS (already have contributions in PERS through this or any other agency), you cannot elect out of PERS. If you are a retired member of PERS, the working retiree restrictions apply. § 19-3-1106, MCA. By signing below, I acknowledge that I understand:

- If I have contributions on account at MPERA, I must contribute to PERS;
- **If I decline membership, I cannot later become a member of PERS while still employed with the same employer but in a different optional position;**
- If I decline membership, terminate employment, and become employed in another optional position within 30 days of termination, I may not become a member in the second optional position;
- If I decline membership, terminate employment, and become employed in another optional position 30 days or more after my termination, I am allowed a new election;
- If I decline membership, I will not receive membership service or service credit for employment for which membership was declined; and
- If I subsequently accept employment in a position for which retirement is mandatory, I must become a member regardless of this election.

I am eligible to choose PERS membership due to employment with this agency and I am **not** an active, inactive or retired member of PERS.

ELECTION

☐ **I decline PERS membership**

☐ **I elect PERS membership (Please complete a PERS Membership Card / Designation of Beneficiary)**

Employee Signature	Date

EMPLOYER INFORMATION – to be completed by employer

Employee's Hire Date	Employing Agency	Employer Number

Please verify the above employee is eligible for optional membership. Working retirees, excluded employees and mandatory members are NOT eligible for an optional membership election. § 19-3-401,403 and 412, MCA.

Check the type of optional position (you must check only one):

☐ Employee directly appointed by the Governor

☐ Chief administrative officer of a city or county

☐ Legislative branch employee working 10 months or less to perform work related to the legislative session

☐ New employee of a county hospital or rest home

☐ Employee working 960 hours or less in PERS-covered positions

Printed Name	Title	Phone Number ( )
Signature		Date

Return completed form to MPERA within 90 days of hire. Retain a copy for your records.

* For identification and tax purposes. §19-2-403(7) MCA, 26 USC § 6041A and 6109

Montana Department of Justice
MVD
Motor Vehicle Division
Safety • Efficiency • Dependability

Release of Driving Records

(Montana Driver Privacy Protection Act)

Print Form

P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-1631

Office

1. Requested Information

[3] ○ **A.** Your Driving Record – Complete Sections 3, 4, 5, and 6.

[3] ◉ **B.** Another Person's Driving Record – Complete all sections, including Intended Use below.

Intended Use: To be completed if you checked B above.

[1] ☐ For use by a federal, state, or local government agency, including a law enforcement agency or any individual acting on behalf of the agency in carrying out its functions.

[2] ☐ For use by a business or its agents, employees, or contractors in their normal course of business to verify the accuracy of personal information submitted by the individual to the business or it agents, employees, or contractors. If the submitted information is not correct or no longer correct, to obtain the correct information for the purposes of preventing fraud by pursuing legal remedies against or recovering on a debt or security interest against the individual.

[4] ☐ With written consent of the individual(s) who is the subject(s) of this search - A signed and dated Personal Information Express Consent form must be attached.

[5] ☐ For use as part of a civil, criminal, administrative, or arbitrative proceeding in any court or government agency or before any self-regulatory body, including the service of process, an investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, pursuant to an order of any court.

[6] ☐ For use by an insurer, insurance support agency, or self-insured entity in connection with the investigation of claims, antifraud activities, ratemaking, or underwriting.

[7] ☐ For use by a licensed private investigator or security service for any purpose authorized under Montana law.

[8] ☐ For use by an employer or its agent to verify information related to a holder of a commercial driver license required under federal or Montana law.

[9] ☐ For use in providing notice to the owners of towed, abandoned, or impounded vehicles.

[10] ☐ For use by a parent of a child under 18 years of age.

[11] ☐ For any other use that is specifically related to the operation of a motor vehicle or to public safety and is authorized under Montana law.

2. Requestor Information

Name of Requestor: Dallas Bowe-Human Resources Department

Employer/Company: (if applicable) Lincoln County

Mailing Address: 512 California Avenue City: Libby State: MT Zip: 59923

Residential Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone #: (406) 283-2312 Driver License #: _____

3. Search Information: This section must be complete.

Full Name: _____

Date of Birth: _____

Driver License #: _____

4. Driving R

Make che **cle Division**

☐ Driving Rec

☐ Certified D rd * Cannot Be Faxed *

☐ Faxing of R cord Fax #: (_____) _____

☐ Mailing of R ailing (unless self-address ed)

5. Certification (Signature must be notarized unless a copy of requestor's driver license or state-issued identification card is enclosed.)

I have read the Montana Driver Privacy Protection Act, MCA 61-11-501 through 61-11-516, and understand the limitations placed on the use of information received from the Montana Department of Justice, Motor Vehicle Division, Records and Driver Control Bureau. Under penalty of law (MCA 45-7-203), I certify that the statements made and information contained on this form are true and correct to the best of my knowledge, information, and belief; I am the person named on this form; and, if signing for a business entity or trust, I have full authority to do so.

Signature of requestor: _____

Printed Name: _____ Date: _____

Section 6 notarization must be com gible copy of your state or government-issued photo ID, including driver license, identifi which can be expired for more than four years.

6. Notarization (unless ID is provided

State of	Cour re me on (date)	Notary Stamp/Seal
By (clearly print name of person signing form)		
Notary signature		

34-0100 (4/14)

Montana Department of Justice
MVD
Motor Vehicle Division
Safety • Efficiency • Dependability

Personal Information Express Consent Form

P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-1631

This form is to be used to authorize the Department of Justice, Motor Vehicle Division, to release certain records to another person or entity. Complete this form if you have checked the first box of the **Intended Use** portion of Section 1 on the Release of Driving Records form (34-0100).

Name: _____
Print Full Name

Driver License #: _____ Date of Birth: _____

Residing at: _____
Street City State Zip Code

I hereby authorize the Department of Justice to release my:
☐ Driving Record ☐ Vehicle Record

To the following individual and/or company:

Name: Lincoln County/H.R. Director Dallas Bowe
Print Full Name

Address: 512 California Avenue Libby MT 59923
Street City State Zip Code

Under penalty of law (MCA 45-7-203), I certify that the statements made and information contained on this form are true and correct to the best of my knowledge, information, and belief; I am the person named on this form; and, if signing for a business entity or trust, I have full authority to do so.

Signature: _____ _____
This is my legal signature Date

Printed name: _____

☑LINCOLN COUNTY

Direct Deposit Authorization

I authorize the Human Resources Department and Lincoln County to initiate electronic credit entries and, if necessary, debit entries and adjustments for any credit entries in error each pay day to my:

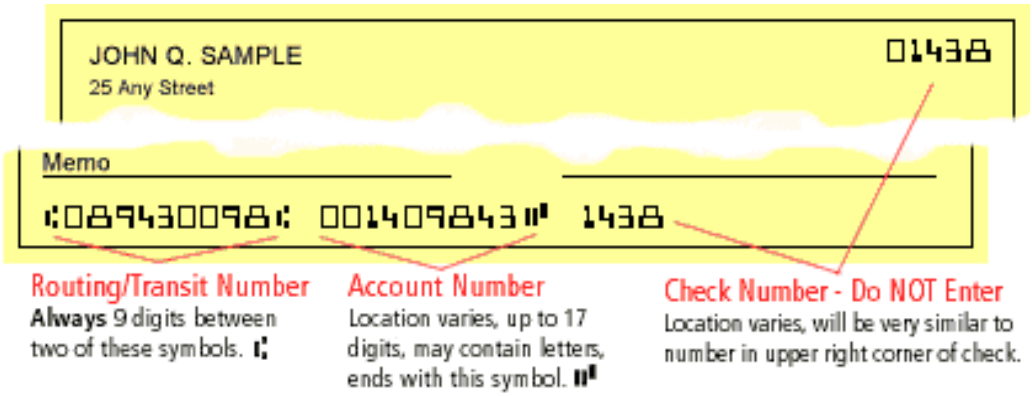
Please Check One

- ☐ Checking Account
- ☐ Savings Account

I understand that this authority will remain in effect until I cancel it in writing.

Name (Please Print)	**Financial Institution**
Signature	**Office or Branch**
Date	**City, State**

Transit/Routing (ABA) No.	**Account Number**



Please attach your voided check or savings deposit to the bottom of this page.

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 **08/01/2023 through 7/30/2024**

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
$680.75	$1,371.85	$1,233.37	$1,925.96

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

_____Employee	_____Employee + Spouse	_____Employee + Child(ren)	_____Family
$643.03	$1,295.51	$1,164.80	$1,818.60

☐ **Waiver Health Insurance Coverage**

Voluntary Dental Insurance – Joint Powers Trust

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

$36.50 $73.01 $76.66 $109.51

☐ No (Waive Dental Coverage)

Voluntary Vision Insurance – Mutual of Omaha

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

Cost with Medical $7.05 $16.89 $18.30 $31.22

☐ 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 _____

Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)

*Employer Name: Lincoln County		Effective Date:	Group ID: G000BQTF
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:			
*City:	*State:	*Zip Code:	

Tobacco Use Section (If you do not complete this section, tobacco premiums will apply. Required fields are marked with an asterisk(*).)

The response to the following questions will determine the premium amount that applies to one or more of the coverages offered below.

	Employee	Spouse
*In the last 12 months, have you smoked a cigarette, cigar or pipe; chewed tobacco; or used tobacco or nicotine in any other form (including forms of nicotine replacement)?	☐ Yes ☐ No	☐ Yes ☐ No

Voluntary Long-Term Disability Coverage Election

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

Basic Life and AD&D Coverage Election

Employee and Dependent Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer
Basic Life - Spouse	☐	☐	_____	Paid by Employer
Basic Life - Child(ren)	☐	☐	_____	Paid by Employer

The following applies to dependent Basic Life coverage:
- The premium amount for spouse and child(ren)is blended – the same premium amount applies whether spouse coverage, child(ren) coverage, or both is/are selected.
- The Child(ren) Benefit Amount listed applies to any child age six months or older. A different benefit amount may apply to any child under the age of six months. Please contact your employer/benefits administrator for additional information.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Accident Coverage Election

Important eligibility information: 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	Select One Coverage Option	Premium Amount
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.

Voluntary Critical Illness/Specified Disease Coverage Election

Health Insurance Information for Critical Illness and 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

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.

- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Vision Coverage Election

Employee and Dependent Coverage	Select One Coverage Option	Premium Amount
Voluntary Vision - Employee Only	☐	$_____
Voluntary Vision - Employee + Spouse	☐	$_____
Voluntary Vision - Employee + Child(ren)	☐	$_____
Voluntary Vision - Employee + Family	☐	$_____
	☐ Decline	

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

Voluntary Life Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Premium Amount
Voluntary Life - Employee	☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____
Voluntary Life - Spouse	☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____
Voluntary Life - 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. The GIA is the lesser of 5 times your annual salary, or $100,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $25,000. In no event shall your amount of insurance exceed 5 times your salary.
- 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 85 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 85.
- 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 dependent(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.)*

ACKNOWLEDGEMENT AND RECEIPT OF HANDBOOK

ACKNOWLEDGEMENT AND RECEIPT OF HANDBOOK OF PERSONNEL POLICIES AND PROCEDURES FOR LINCOLN COUNTY

I acknowledge receipt of a copy of the Handbook of Personnel Policies and Procedures adopted by Lincoln County. I understand that I will be responsible for complying with the terms and conditions contained in the Handbook.

DATED this _____ day of _____.

Employee's signature: _____

Employee's hand-printed name: _____

Employee's work location: _____

Employee's Position Title: _____

APPENDICES

IMPORTANT NOTE

In addition to the Acknowledgement and Receipt of Handbook on page 1, which holds all employees responsible for complying with the terms and conditions of every policy contained in this Handbook, employee signatures are required on the forms provided in Appendices A through D.

Employees who are engaged in safety-sensitive positions are also required to sign the form in Appendix E.

APPENDIX A: Equipment Acknowledgement Form

Lincoln County

I acknowledge that while I am working for the County, I will take proper care of all County equipment with which I am entrusted. I shall abide by all the guidelines set forth in **Use of Vehicles and Equipment** in this Handbook including, but not limited to; using equipment lawfully, safely, and cost-effectively; for its designed purpose; for County business only; and according to the manufacturer's specifications.

I understand that, while County equipment is in my possession, any abuse, violations of safety practices, or disregard for the proper care and maintenance of such equipment may result in disciplinary action, up to and including termination.

I further understand that, upon termination, I shall return all property of the County and that the property will be returned in proper working order. This agreement includes, but is not limited to, the following: laptops, cell phones, pagers, IT equipment, tools, personal protective gear, and any other equipment the County has provided for use with my job.

I understand that failure to return equipment shall be considered theft and will lead to criminal prosecution by the County.

_____

Employee Name (please print)

_____ _____

Employee Signature Date

APPENDIX B: Ethics and Conflict of Interest Acknowledgement Form

Lincoln County

By my signature below, I acknowledge that I have received a copy of the **Ethics and Conflict of Interest Policy.** I understand it is my obligation to read, understand, and comply with the stipulations, procedures, and provisions contained within this Policy. I understand that I am responsible for abiding by the County Code of Ethics contained in this Policy as I conduct my assigned duties during my term of employment.

I understand that if I am found to be in violation of the provisions set forth in the **Ethics and Conflict of Interest Policy**, that I am subject to discipline, suspension, termination, and/or such other action as the County deems appropriate.

I certify that I have read and understand the above statement and acknowledge that this form will be placed in my personnel file.

_____
Employee Name (please print)

_____ _____
Employee Signature Date

APPENDIX C: Drug and Alcohol Free Workplace Acknowledgement Form

Lincoln County

As an employee of the County, I certify that I shall not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while on County property or while conducting any activity involving the County.

By my signature below, I acknowledge that I have received a copy of the Drug and Alcohol Free Policy of the County. I understand that it is my obligation to read, understand, and comply with the procedures and provisions contained within this Policy.

I understand that if I am found to be in violation of the provisions set forth in the **Drug and Alcohol Free Workplace Policy** in this Handbook, I am subject to suspension, termination, participation in a drug rehabilitation program, and/or such other action as the County deems appropriate.

I certify that I have read and understand the above statement and acknowledge that this form will be placed in my personnel file.

_____
Employee Name (please print)

_____ _____
Employee Signature Date

APPENDIX D: Computers, Internet, and Email Policy Acknowledgement Form

Lincoln County

By my signature below, I acknowledge that I have received a copy of the **Computers, Internet, and Email Policy.** I understand that it is my obligation to read, understand, and comply with the stipulations, procedures, and provisions contained within this policy.

Further, I understand that this policy governs my use of all County technology and, under certain circumstances, my own technology that I might bring into the County (See **Personal Telephone Calls and Personal Communication Devices).**

Additionally, I understand that if I violate the policy, I am subject to discipline from the County, including suspension, termination, and/or such other action as the County deems appropriate. I also understand that some violations of this policy could result in actions against me both civilly and criminally and in both federal and state courts. I also understand that I have no expectation of privacy in any of the technology referenced in the policy, due to the access and interception rights reserved by and granted to the County.

I certify that I have read and understand the above statement and acknowledge that this form will be placed in my personnel file.

_____
Employee Name (please print)

_____ _____
Employee Signature Date

APPENDIX E: Drug Testing Acknowledgement Form

Lincoln County

The County's drug testing program typically applies to individuals engaged in the performance, supervision, or management of work in a hazardous work environment, security positions, positions affecting public safety or public health, positions in which driving is part of the job, or a fiduciary position for the County. **The County must specifically identify all positions covered by its Drug and Alcohol Testing Policy and ensure that these employees are notified of this designation in accordance with Montana law. New employees shall be informed in the offer letter if their position is subject to drug testing.**

As an employee and/or applicant of the County designated to submit to the drug testing procedures outlined in the Drug Testing Policy, I hereby acknowledge that the County's Drug Testing policy requires me to submit to drug testing and/or breath alcohol testing to rule out the presence of unprescribed or prohibited dangerous controlled substances in my system. I hereby freely and voluntarily consent to this request for a drug test and/or alcohol test, and agree to participate in the testing program.

I hereby release the County, its employees, agents, and contractors from any and all liability what-soever arising from this request for testing, from the actual testing procedures, and from decisions made concerning my application for or continuation of employment based on the results of the analysis. I hereby agree to cooperate in all aspects of the testing program.

I understand that, if I am found to be in violation of the provisions set forth in the **Drug Testing** and/or **Drug and Alcohol Free Workplace Policy**, I am subject to suspension, termination, participation in a drug rehabilitation program, and/or such other action as the County deems appropriate.

I certify that I have read and understand the above statement and acknowledge that this form will be placed in my personnel file.

_____
Employee Name (please print)

_____ _____
Employee Signature Date

APPENDIX F: Decedent's Warrant or Paycheck Designation Form

LEGAL DESIGNATION OF PERSON AUTHORIZED TO RECEIVE DECEDENT'S CHECK(S)

1. Complete the Primary & Contingent Beneficiary Designation portion of this form. This form must be typed or printed legibly in ink.
2. Provide designee's full legal name (example "Mary Lynn Smith"). The designee name cannot be "Mrs. John E. Smith" or "To the Estate of Jane Smith".
3. No erasures or corrections in the designee's name can be accepted. If an error is made, complete a new form.
4. Inform the County Clerk & Recorder when designee's address changes.
5. Sign this form in ink and submit to the County Clerk & Recorder
6. Designee may be changed at any time by completing another form and submitting to the County Clerk & Recorder or Human Resources Department. You are requested to update your designee every calendar year.
7.

BENEFICIARY DESIGNATION FOR DECEDENT'S FINAL CHECK(S)

Pursuant to §2-18-412, MCA, I hereby designate the following person who, notwithstanding any other provision of law, shall be entitled upon my death to receive all MACo checks excluding payment of death benefits and refund of employee retirement contributions, payable to me as a result of my employment with the Montana Association of Counties had I survived.

Primary Beneficiary Information – All information is required

Name of Designee_____
First Middle Last
Mailing Address_____
Street or PO Box City State Zip Code
Social Security Number_____ Date of Birth_____ Phone#_____

Contingent Beneficiary Information – All information is required

*In the event that your primary beneficiary does not survive you, your check(s) will be issued to your contingent beneficiary.

Name of Designee_____
First Middle Last
Mailing Address_____
Street or PO Box City State Zip Code
Social Security Number_____ Date of Birth_____ Phone#_____

My signature on this document indicates:

1. I understand this is a legally binding document.
2. I hereby revoke any previous designation filed by me
3. If the above named designees cannot be contacted within sixty days after the date of my death, this designation shall be void and the check will be reissued to my estate.
4. This designation will remain in full force and effect until revoked by me in writing.

Employee Name_____
First Middle Last
Social Security Number_____ Date_____

Signature_____