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

Company Name: Lincoln County	Group #: 0001702	ID #:

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:
DOB:		DOB:	

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.)	**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 / /	Signature Date / /

This Section Is To Be Completed By Employer

Division Name: Active/COBRA/Retiree Division #: _____ PPO _____ Date of Hire _____

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

Occupation: _____ Earnings: $ N/A Life Insurance (if applicable) $ _____

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

ELECTION FORM

Lincoln County **08/01/2025 through 7/31/2026**

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
$768.80	$1,549.29	$1,1392.90	$2,175.08

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

_____Employee	_____Employee + Spouse	_____Employee + Child(ren)	_____Family
$726.21	$1,463.08	$1,315.46	$2,053.83

☐ **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:		E-mail Address:	
*City:	*State:	*Zip Code:	Telephone: ( ) -

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	$_____

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
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

- 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.

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 Life Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Premium Amount
Voluntary Life - Employee	☐ $20,000	$_____
	☐ $50,000	$_____
	☐ $70,000	$_____
	☐ $100,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life - Spouse	☐ $5,000	$_____
	☐ $10,000	$_____
	☐ $15,000	$_____
	☐ $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.

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.

Dependent Information (If you enrolled dependents for insurance, you must complete this section. Please print clearly.)

If you need to list more dependents than space will allow, please include this information on a separate piece of paper and submit it with this form.

Name of Dependent Last name	First Name	Gender	Relationship to Employee	Birth Date (MM/DD/YYYY)

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.)*