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. Benefit Enrollment Form _____
12. Health Insurance Form _____

Lincoln County Personnel Policies and Procedures:

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

LINCOLN COUNTY
NEW EMPLOYEE PAYROLL INFORMATION SHEET

1. Name: _____

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

3. Work or Home Email Address: _____

4. Social Security #: _____ Birth Date: _____

5. Race:
   - Asian:_____
   - Black:_____
   - Hispanic:_____
   - American Indian: _____
   - Other:_____
   - Unspecified:_____
   - White: _____

6. Job Title/Position: _____

7. Beginning Salary:_____after 6 Months _____

8. Starting Date:_____Workers Comp Class Code: _____

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

10. Hours per week regularly scheduled to work: _____

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./S.R.S. Eligible: _____ Yes _____ No
    (Anyone Scheduled to work over 960 hours per year must contribute)

LINCOLN COUNTY
NEW EMPLOYEE PAYROLL INFORMATION SHEET

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

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

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

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

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)

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,

Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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:

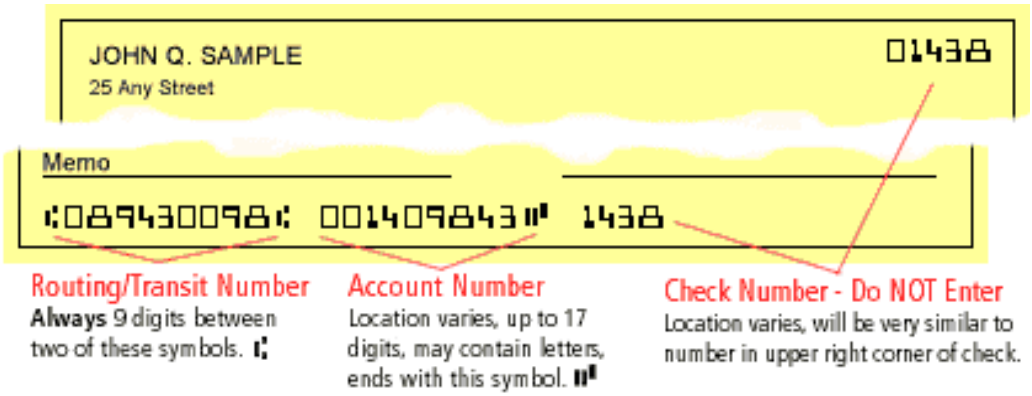
Please Check One

- ☐ 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.

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.)*

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_____