2021 Staff Benefit Enrollment/Change Form

1. PERSONAL INFORMATION

Employee Last Name	Employee First Name	M.I.	Employee Payroll ID or Social Security No.

Mailing Address (street, city, state, zip code)	Telephone Number

2. EMPLOYEE ACTION

Changes outside of the annual open enrollment period must be related to a qualified event that allows for special enrollment. Employees must submit a completed form ***within 31 days of the qualifying change*** in family or employment status and **provide proof** of the qualifying status change.

Date of Event (when the event occurred): ___________/___________/___________

Check below the event that triggered the change:

☐ New Hire Rehire ☐ Birth Adoption ☐ Marriage ☐ Domestic Partnership Registration ☐ Divorce ☐ Loss/Gain of Coverage ☐ Legal Custody Court Order ☐ Death ☐ Other (explain)

3. MEDICAL PLANS *(check one box)*

☐ Traditional Health Plan
☐ Health Savings Plan
☐ Waive Medical Coverage

WHO ARE YOU ENROLLING IN MEDICAL COVERAGE? *(check one box if electing medical coverage)*

☐ Employee Only ☐ Employee + Children
☐ Employee + Spouse/Registered Domestic Spouse ☐ Family

4. DENTAL PLAN *(check one box)*

☐ Employee Only ☐ Employee + Spouse/Registered Domestic Spouse ☐ Employee + Children ☐ Family ☐ Waive Coverage

5. VISION PLAN *(check one box)*

☐ Employee Only ☐ Employee + Spouse/Registered Domestic Spouse ☐ Employee + Children ☐ Family ☐ Waive Coverage

6. DEPENDENT INFORMATION

If you selected dependent coverage under the medical, dental, vision, supplemental life or AD&D, and/or voluntary protection plans, record the names of all dependents below. This information provides a record of who is covered to the insurance company. *We will not be able to process your request for dependent coverage without date(s) of birth and Social Security number(s).* **Your dependents may not enroll unless you are also enrolled. A dependent does not include anyone who is also enrolled as an employee. No one can be a dependent of more than one employee.**

Action	Full Name (Last, First, M.I.)	Relationship (Spouse, son, daughter, stepchild, etc.)	Gender (M or F)	Birth Date (MM/DD/YYYY)	Social Security No.
☐ Add ☐ Change ☐ Delete					
☐ Add ☐ Change ☐ Delete					
☐ Add ☐ Change ☐ Delete					
☐ Add ☐ Change ☐ Delete					
☐ Add ☐ Change ☐ Delete					
☐ Add ☐ Change ☐ Delete					

7. AUTHORIZATION AND STATEMENT OF ELIGIBLE DEPENDENTS FOR THE HEALTH AND WELFARE PLANS

The health and welfare plans offered by the company give an eligible employee the opportunity to enroll an eligible dependent(s) under the benefits during specific timeframes. To be eligible for Kiewit benefits, a dependent must meet one of the criteria outlined below.

Your lawful spouse (opposite or same sex) from either a licensed marriage, registered common-law marriage or registered domestic partner relationship

- Registered common-law marriage is defined by each state. For common-law spouse insurance under this plan, you will need to meet the definition of a common-law marriage for the state in which you reside. You must not be legally separated from your spouse and you **must be registered with a state or local government common-law registry**.
- Registered domestic partner relationship is defined as a relationship with an individual of the same or opposite sex where both partners must: not be so closely related that marriage would otherwise be prohibited; not be legally married to, or the domestic partner of, another person under either statutory or common law; be at least 18 years old; live together and share the common necessities of life; be mentally competent to enter into a contract; and be financially interdependent. You **must be registered with a state or local government domestic partner registry**.

Your or your spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian

- A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO)

An unmarried child age 26 or over who is or becomes disabled and dependent upon you and was incapacitated prior to the date on which the insurance would have otherwise ended.

If you are enrolling a spouse, registered domestic partner, registered common-law spouse, step-child or child of registered domestic partner/common-law spouse, provide the following information:

☐ Spouse (**Legally** Married) ☐ **Registered** as Domestic Partner with any state or local domestic partnership registry ☐ **Registered** as Common-Law with any state that recognizes common-law marriage

County of Marriage, Common Law Registration or Domestic Partnership Registration	**City** of Marriage, Common Law Registration, or Domestic Partnership Registration	**State** of Marriage, Common Law Registration or Domestic Partnership Registration	**Date** of Marriage, Common Law Registration or Domestic Partnership Registration

8. AUTHORIZATION AND SIGNATURE (REQUIRED TO AUTHORIZE CHANGES)

I have read the statement in Section 7 and, if applicable, confirm that I have enrolled only eligible dependents in the health and welfare plans. **I understand that if I knowingly file a statement claim containing any misrepresentation or any false, incomplete or misleading information, it may result in immediate termination of employment.**

I have also read about my benefits choices under the Kiewit Benefits Plan. I authorize the choices I have made and the payroll deductions necessary for those benefits. I understand these choices will remain in effect for the entire calendar year, unless I have a change in family status. If I make contributions to Health Care and/or Dependent Day Care Spending Accounts, I understand expenses must be incurred in the same Plan Year deposits are made and any funds left over after the close of the Plan Year will be forfeited.

Employee Signature: ______________________________ **Date:**______________

<<<Form will NOT be processed without a signature>>>

9. DECLARATION OF TAX DEPENDENT (REGISTERED DOMESTIC PARTNERS ONLY)

I understand that Peter Kiewit Sons', Inc. (and its subsidiaries) has not provided tax advice to me on this matter, and that I am responsible for consulting with my own tax advisor regarding this matter, including consequences of making this declaration. I have reviewed IRS Publication 501.

Please check the appropriate box below.

☐ I hereby certify that the above named registered domestic partner (and children if applicable) that I am enrolling for health insurance coverage **does** qualify, and I claim them as dependents under IRC Section 152 for the ___________ tax year. **I understand that falsely certifying dependency status could result in disciplinary action up to and including termination of employment.** I further agree to notify Peter Kiewit Sons', Inc. immediately of any change in this tax status.

☐ I hereby certify that the above named registered domestic partner (and children, if applicable) that I am enrolling in health insurance coverage **does not** qualify, and I do not claim them as dependents under IRC Section 152 for the ___________tax year. I understand that the fair market value of group health insurance coverage provided by Peter Kiewit Sons,' Inc. to cover my domestic partner will be treated as taxable income to me. I further understand that the portion of premiums I pay for this coverage must be paid for on an after-tax basis.

Employee Signature:______________________________ **Date:** ______________

10. 2021 FLEXIBLE SPENDING ACCOUNTS (FSA)

The Plan Year begins on your insurance effective date through Dec. 31 of the current Plan Year. Any changes in the annual contribution, due to a life event, can only be used from the life event date to Dec. 31 of the current Plan Year. **Any funds left over in this account after the close of the Plan Year will be forfeited.** For the Health Care FSA, you will be automatically signed up for automatic claims submission and have the option to have your reimbursement directly deposited into your bank account. You can go to www.myuhc.com to remove the automatic claims submission feature, sign up for direct deposit or to submit claims online for reimbursement. The contribution amount you elect to put into your FSA will be divided by how many pay periods are remaining in the Plan Year. For more information about this plan, refer to the Flexible Spending Account Summary Plan Description found at myjobbenefits.com (password: kiewithealthy).

A) Health Care FSA (Available if enroll in the Traditional Plan or waiving coverage)	☐ I elect $__________________ as my annual contribution amount (min $72, max $2,750)	☐ I do not want a Health Care FSA
B) Limited Purpose FSA (Available if enrolled in the Health Savings Plan)	☐ I elect $__________________ as my annual contribution amount (min $72, max $2,750)	☐ I do not want a Limited Purpose FSA
C) Dependent Care FSA	☐ I elect $__________________ as my annual contribution amount (min $72, max $5,000)	☐ I do not want a Dependent Day Care FSA

11. HEALTH SAVINGS ACCOUNT (HSA)

Available to employees who enroll in the Health Savings Plan (HDHP) and meet listed eligibility criteria.

- Are covered by an HSA-qualified high-deductible health plan (HDHP) on the first day of a given month.
- Are not covered by any other non-HSA-eligible health plan (dental, vision, disability and some other types of additional coverage are permissible).
- Are not enrolled in Medicare, TRICARE or TRICARE for Life.
- Are not eligible to be claimed as a dependent on someone else's tax return.
- Do not have a health care flexible spending account (FSA) or health reimbursement account (HRA). Alternative plan designs, such as a limited-purpose FSA or HRA, might be permitted.

Once the HSA account has been opened with Optum Bank, Kiewit will receive notification and can then start the employee and /or employer pretax contributions via payroll deduction and remit those contributions to Optum Bank.

For 2021, IRS regulations state you can have total HSA contributions up to $3,600 if you have individual coverage and $7,200 if you have a family coverage. The IRS also allows you to make an extra catch-up deposit of $1,000 if you are 55 or older. **Kiewit will make weekly contributions of $9.61 for single coverage and $19.23 for employee + dependent coverage. These employer contributions count toward the IRS maximum.**

☐ **Weekly Contribution $__________________** (Must enroll in the Health Savings Medical Plan)

By signing below, I acknowledge and certify that:

- ✓ I wish to establish a health savings account (HSA) with Optum Bank as custodian.
- ✓ I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed the information in the Summary Plan Description Benefit Description Guide and understand and agree that my HSA will be opened under and governed by Optum Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding to me. This document will be sent to me when my account is opened, along with Optum Banks's Privacy Policy and Schedule of Fees.
- ✓ I authorize Optum Bank to provide information about my HSA, including my account number, to my employer (if applicable) and those acting on behalf of my employer or Optum Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- ✓ I acknowledge that my employer and all others acting on behalf of my employer (if applicable), may provide information on my behalf to establish and maintain my HSA and authorize my employer and its designee to take such action deemed necessary and appropriate by my employer to administer my HSA, including but not limited to, making deposits and correcting errors when necessary.
- ✓ I understand my monthly account statement will be made available electronically. I agree to notify Optum Bank if I wish to have statements mailed to my home address.
- ✓ I have requested a MasterCard Prepaid Debit Card.
- ✓ I certify that the information provided in this application is true and complete.

PER THE U.S. PATRIOT ACT:

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth and other information that will allow us to identify you. We also ask to see your driver's license or other identifying documentation.

IMPORTANT: We cannot process your HSA without your signature. By signing below, you agree that we can rely on your signature for authorization of withdrawals and other transactions on your account.

Employee Signature: ____ **Date:**______________________________

Must sign if enrolling in the Health Savings Medical Plan

12. SUPPLEMENTAL LIFE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

For the purposes of this enrollment form, wherever the term spouse appears, it shall also include registered domestic partner (DP).

A) Supplemental Life Insurance

To qualify for the guarantee issue amount, you must elect coverage within 31 days of becoming eligible for life insurance or qualifying family status change.

Monthly Premiums			
Employee/Spouse Age	**Employee Monthly Cost Per Unit (1 unit = $10,000)**	**Spouse Monthly Cost Per Unit (1 unit = $5,000)**	**Child Monthly Cost Per Unit (1 unit = $2,000)**
Under 25	$0.50	$0.25	$.16
25 to 29	$0.60	$0.25	
30 to 34	$0.80	$0.25	
35 to 39	$0.90	$0.45	
40 to 44	$1.10	$0.55	
45to 49	$1.80	$0.90	
50 to 54	$3.20	$1.60	
55 to 59	$4.90	$2.45	
60 to 64	$7.90	$3.95	
65 to 69	$13.70	$6.85	
70 & over	$20.60	$10.30	

Employee (1 unit = $10,000)	**Spouse (1 unit = $5,000)**	**Dependent Child(ren) (1 unit = $2,000)**
The minimum coverage amount is 1 unit and the maximum are 100 units, **not to exceed eight times your annual base hourly wage**. You can enroll without showing Evidence of Insurability if you elect a coverage amount up to five times your annual base hourly wage, to a maximum of 20 units, anything over that amount would require Evidence of Insurability.	The minimum coverage is 1 unit and the maximum coverage is 50 units, **not to exceed one-half of the employee's coverage amounts**. You can enroll your spouse without showing Evidence of Insurability if you elect a coverage amounts up to 10 units. Anything over that amount requires Evidence of Insurability.	The dollar amount you indicate will represent the amount for each child. You can **elect coverage from 1 unit to 5 units.**
☐ ________________**Units**	☐ ________________**Units**	☐ ______________**Units**
☐ **Waive**	☐ **Waive**	☐ **Waive**

B) Supplemental Accidental Death & Dismemberment (AD&D) Insurance

If you select coverage for your family, benefits for family members will be a percentage of yours.

1) How much AD&D coverage do you want?

_________________ **Units**

(Max of 50 units)

2) Who are you covering?

☐ Employee Only

☐ Employee + Family

☐ Waive

Monthly Premiums (Can elect coverage in increments of 1 unit) 1 unit = $10,000	
Employee	Employee and Family
$0.26 per 1 unit	$0.42 per 1 unit

C) Beneficiary(ies)

☐ **Basic Life** ☐ **Basic AD&D** ☐ **Supplemental Life** ☐ **Supplemental AD&D**

	Full Name	**Percentage**	**Address**	**Relationship**
Primary (First in line to receive)				
Contingent (Second in line to receive if primary is unable)				

I will be my family members' beneficiary unless I notify Kiewit otherwise in writing. Benefits will not be paid to my registered domestic partner if he/she is not specifically designated. I enroll and authorize my employer to deduct the premiums from my earnings. I understand that the insurance selected will begin on the effective date as described in the brochure. If I am not actively at work, or my family members are not actively at work, or they are unable to engage in all the usual duties of a person of like age and sex, the effective date of coverage will be delayed until the individual returns to work, or the family member resumes usual duties.

Employee Signature: ____ **Date:** _____________________

13. VOLUNTARY PROTECTION PLANS

You must elect coverage within 31 days of becoming eligible for the protection plans or qualifying family status change, otherwise you cannot enroll until the next open enrollment period. No one can be a dependent of more than one employee.

A) VOLUNTARY ACCIDENT PROTECTION PLAN *(check one box)*

☐ Employee Only $9.73/month	☐ Employee + Spouse $15.54/month	☐ Employee + Child(ren) $12.42/month	☐ Family $18.23/month	☐ Waive Coverage

B) VOLUNTARY CRITICAL ILLNESS PROTECTION PLAN

Voluntary Critical Illness Protection Benefit Options			
	Option 1	Option 2*	Option 3*
Employee	$5,000	$10,000	$20,000
Spouse	$2,500	$5,000	$10,000
Child(ren)	$1,250	$2,500	$5,000

***Employee may choose from lower coverage options for spouse and Child(ren)**

Employee Monthly Premiums per $1,000		
Employee Age	**Non-Tobacco**	**Tobacco**
Under 25	$0.22	$0.25
25 to 29	$0.31	$0.34
30 to 34	$0.39	$0.46
35 to 39	$0.52	$0.68
40 to 44	$0.72	$1.06
45 to 49	$1.20	$2.24
50 to 54	$1.83	$3.24
55 to 59	$2.63	$4.80
60 to 64	$4.08	$7.99
65 to 69	$5.67	$10.99
70 to 74	$8.26	$16.99
75 +	$10.50	$19.63

Spouse Monthly Premiums per $1,000		
Spouse Age	**Non-Tobacco**	**Tobacco**
Under 25	$0.21	$0.22
25 to 29	$0.29	$0.32
30 to 34	$0.38	$0.43
35 to 39	$0.53	$0.63
40 to 44	$0.79	$1.02
45 to 49	$1.17	$1.69
50 to 54	$1.60	$2.54
55 to 59	$2.14	$3.70
60 to 64	$3.04	$5.63
65 to 69	$4.36	$8.46
70 to 74	$6.01	$11.19
75 +	$8.33	$14.20

Child(ren) Monthly Premiums per $1,000
$0.16
The premium amount will represent the amount for each child.

Employee must purchase coverage to purchase on spouse and/or child(ren). **Coverage for spouse and/or children cannot be higher than the employee coverage.** *Check the appropriate boxes:*

Who are you enrolling in Vol. Critical Illness Plan?	Indicate the protection option you want to buy (1,2, or 3)	Indicate tobacco usage	If you don't want coverage, check waive
Employee	________________Option	☐ Tobacco ☐ Non-Tobacco	☐ Waive Coverage
Spouse	________________Option	☐ Tobacco ☐ Non-Tobacco	☐ Waive Coverage
Dependent child(ren)	________________Option	N/A	☐ Waive Coverage

C) HOSPITAL INDEMNITY PLAN *(check one box)*

☐ Employee Only $16.42/month	☐ Employee + Spouse $42.72/month	☐ Employee + Child(ren) $33.89/month	☐ Family $64.15/month	☐ Waive Coverage

D) Beneficiary(ies)

☐ **Accident Plan** ☐ **Critical Illness Plan** ☐ **Hospital Indemnity Plan**

	Full Name	Percentage	Address	Relationship
Primary (First in line to receive)				
Contingent (Second in line to receive if primary is unable)				

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued. All statements made by me are representations and, not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me and, a copy of the statement is furnished to me or my beneficiary.

Employee Signature: ____ **Date:** _________________________

Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment **within 31 days** after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have new dependents as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your eligible dependents if you are already enrolled. However, you must request enrollment **within 31 days** after the marriage, birth, adoption or placement for adoption.

If you or your dependents lose coverage under Medicaid or the Children's Health Insurance Program (CHIP), or become eligible to participate in a Medicaid or CHIP premium assistance program, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment **within 60 days** after your or your dependents' other coverage ends or after becoming eligible for premium assistance.

To request special enrollment or obtain more information, contact the Benefits Department at 855-329-7907 or benefits@kiewit.com

Information Regarding Taxation of Health Benefits for Registered Domestic Partners

If you have a registered domestic partner, the tax treatment of the health insurance coverage that is provided to your domestic partner (or his/her dependent child) depends on whether such individual qualifies as your "dependent" under Section 152 of the Internal Revenue Code. If such individual qualifies as an Internal Revenue Code Section 152 dependent, then the health insurance coverage provided by your employer is not subject to federal income tax. Additionally, your portion of the cost of such coverage can be provided on a pretax basis through your employer's Section 125 plan and claims for expenses not covered by the health insurance can be reimbursed through a health care flexible spending account.

If such individual does not qualify under Section 152, then the value of employer provided health care coverage must be taxed, and premiums for your portion of the cost of the coverage must be paid on an after-tax basis.

A plan can be disqualified if health coverage is paid for on a pretax basis for a domestic partner (or his or her child) that is not a Section 152 dependent of the employee, or if the employer pays the premiums for such health coverage without imputing income to the employee. Generally, to qualify as an IRC Section 152 dependent of an employee during a given tax year, the registered domestic partner (or his or her child, if applicable) must be a "qualifying relative" of the employee. To be a "qualifying relative," the registered domestic partner (or child) must meet the following requirements:

1. Have the same principal place of residence as the employee for the full tax year, except for temporary absences such as vacation, military service or education. Unless the domestic partnership commences precisely on Jan. 1, the registered domestic partner or their child (if applicable) cannot be considered a Section 152 dependent during the first year of the relationship. Similarly, if the Domestic Partnership dissolves other than on Dec. 31, for reasons other than the death of the domestic partner, the tax exclusion is lost for the entire year. If the relationship terminates due to the death of the domestic partner, the domestic partner would continue to be treated as a dependent for the entire tax year.
2. Be a member of the employee's household for the entire calendar year (and the relationship must not violate local law)
3. Receive more than half of his or her support from the employee*****
4. Not be the employee's (or anyone else's) "qualifying child" under Code Section 152, and
5. Be a U.S. citizen, U.S. national or resident of the U.S., Canada or Mexico.

*****The rules for determining whether the registered domestic partner receives more than half of his or her total support from the employee is complicated and more involved than just determining who the "primary breadwinner" is. Total support includes amounts spent to provide food, lodging, clothing, education, medical and dental care, recreation, transportation and similar necessities. In IRS Publication 501, the IRS provides a worksheet that can be used to determine whether an individual meets the support test required to be a qualifying relative. This worksheet is available at http://www.irs.gov/pub/irs-pdf/p501.pd.

NOTE: The foregoing information is only general guidance and does not represent tax planning advice to employees. Employees are responsible for consulting with a tax advisor to determine and understand whether the above requirements are met and any other tax planning or consequences relating to this matter.