International 2026 Open Enrollment Form

(Annual Open Enrollment Period Oct. 27 – Nov. 14, 2025)

Use this form ONLY for ANNUAL OPEN ENROLLMENT changes. Changes will take effect 1/1/2026. For all other benefit changes (e.g., new hire elections), use the standard 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. MEDICAL, DENTAL AND VISION COVERAGE UNDER THE UHC GLOBAL PLAN (CHECK ONE BOX)

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

3. DEPENDENT INFORMATION

If you selected dependent coverage under UHC Global plan, 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					
☐ Add ☐ Change ☐ Delete					

4. 2026 FLEXIBLE SPENDING ACCOUNTS (FSA) WITH FIDELITY

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. **Funds do NOT carry over from one year to another. Any funds left over in these accounts after the close of the Plan Year will be forfeited.** You can go to www.netbenefits.com to manage your account online. 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 www.myjobbenefits.com (password: kiewithealthy).

A) Health Care FSA ☐ I elect **$**_____ as my annual contribution amount ☐ I do not want a Health Care FSA
(min $72, max $3,300)

B) Dependent Care FSA ☐ I elect $_____ as my annual contribution amount ☐ I do not want a Dependent Care FSA
(min $72, max $7,500)

5. 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 time frames. 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 30, 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 aged 30 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, stepchild, 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** Marriage, Common Law Registration or Domestic Partnership Registration	**Date** of Marriage, Common Law Registration or Domestic Partnership Registration

6. AUTHORIZATION AND SIGNATURE (REQUIRED TO AUTHORIZE CHANGES)

I have read the statement in Section 5 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 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>>>

7. 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: _____