

**LOGAN COUNTY**  
**INSURANCE ENROLLMENT FORM**  
For new enrollments and enrollment changes

**PLEASE READ COMPLETELY**

DEPARTMENT NAME

Employee Information:

LAST NAME

FIRST NAME

MIDDLE

Social Security Number

---

**Please choose ONE option from below:**

**PPO 4a**

SINGLE @\$70 MOS.

FAMILY @\$176 MOS.

*\*deductions divided by two paychecks per month*

If you wish to enroll in family coverage and currently have a single policy (or vice versa), a new CEBCO application must be completed. Except for annual open enrollment, no additions may be made without a qualifying event, which may be subject to medical underwriting and may possibly be denied by the insurance carrier.

By signing below I authorize the Logan County Auditor to take the above deductions from my regular pay. In the event a pay deduction is not taken from my regular pay, I agree to make payment by cash or check for the required deduction amount upon notification by the Logan County Commissioners office. I authorize Logan County to change my health insurance deduction amount at each annual open enrollment to the amount established by the Board of Logan County Commissioners for the plan option I have selected above.

---

Employee Signature

Date