2026 Kiewit Craft Benefit Election 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 must be related to a qualified event that allows for special enrollment. Employees must submit a completed form ***within 31 days of the qualifying life status*** and **provide proof** of the qualifying status change.

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

Check below the event that triggered the change *(check one box)***:**

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

3. MEDICAL COVERAGE UNDER CRAFT PLAN WITH UNITEDHEALTHCARE *(check one box)*

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

4. DENTAL COVERAGE WITH DELTA DENTAL OF NEBRASKA *(check one box)*

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

5. VISION COVERAGE WITH VSP *(check one box)*

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

6. DEPENDENT INFORMATION

If you selected dependent coverage under the medical, dental, vision, supplemental life and/or AD&D 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 the 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					

7. 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 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 aged 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, 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** 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 THE 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 qualifying 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>>>

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) 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) 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. 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 this account 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: kiewitbenefits).

A) Health Care FSA *(choose one)*

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

B) Dependent Care FSA *(choose one)*

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

11. VOLUNTARY LONG-TERM DISABILITY

You can enroll in voluntary long-term disability insurance. Voluntary long-term disability insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period, of 180 days. This plan provides you with income protection to replace up to 60% of your earnings, to a maximum monthly benefit of $6,000**.** If you enroll within 31 days of becoming eligible to enroll in Voluntary Long-Term Disability coverage, your coverage is provided to you on a guaranteed issue basis – no medical information is required. If you enroll after this enrollment period, Evidence of Insurability will be required for all coverage amounts.

If you would like to calculate your monthly cost, use the following formula:

$_____ / 12 = _____ / 100 = _____ X $.918 = $_____
Annual Earnings | Your Monthly Earnings | Monthly Cost

Check one box below:

☐ I **elect to purchase** long-term disability coverage.

☐ I **decline** to purchase long-term disability coverage.

By signing below, I acknowledge and certify that:

- ✓ I acknowledge that I have been given the opportunity to enroll in the disability insurance coverage described in the benefit highlight sheets and offered through Peter Kiewit Sons', Inc.
- ✓ I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.
- ✓ I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms, and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations, and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.
- ✓ If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.
- ✓ I authorize my employer to make the appropriate payroll deductions from my earnings.
- ✓ I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Employee Signature: _____ Date: _____

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

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

MONTHLY COST PER UNIT BASED ON AGE

AGE	Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 & over
Employee (1 unit = $10,000)	$0.50	$0.60	$0.80	$0.90	$1.10	$1.80	$3.20	$4.90	$7.90	$13.70	$20.60
SPOUSE (1 unit = $5,000)	$0.25	$0.25	$0.25	$0.45	$0.55	$0.90	$1.60	$2.45	$3.95	$6.85	$10.30

CHILD Monthly Cost Per Unit (1 unit = $2,000)
$0.16

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 5 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?	**2. Who are you covering?**	**Monthly Premiums** (Can elect coverage in increments of 1 unit) 1 unit = $10,000	
	☐ Employee Only	Employee	Employee and Family
_____ **Units** (Max of 50 units)	☐ Employee + Family	$0.26 per 1 unit	$0.42 per 1 unit
	☐ Waive		

C) BENEFICIARIES - You are automatically provided $50,000 basic life & basic AD&D coverage at no cost.

It is important that you designate beneficiaries for your Life & AD&D policies. The selected beneficiaries will receive any eligible death benefits in the event something happens to you. You will be your family member's beneficiary unless you notify the company otherwise in writing.

☐ **Basic Life** (Company Provided) ☐ **Basic AD&D** (Company Provided) ☐ **Supplemental Life** ☐ **Supplemental AD&D**

	Full Name	Percentage	Address	Relationship
Primary (First in line to receive)				
Primary beneficiary percentages must total 100% to be valid		**100%**		
Contingent (Second in line to receive if primary is unable)				
Contingent beneficiary percentages must total 100% to be valid		**100%**		

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 unable to engage in all the usual duties, the effective date of coverage will be delayed until the individual returns to work.

Employee Signature: _____ **Date:** _____

(Signature required for beneficiaries to be valid)

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 towards you 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 towards the other coverage).

In addition, if you have new dependents 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 you 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 will 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 utilized for determining 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.pdf.

NOTE: The foregoing 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.

HOW TO RETURN YOUR COMPLETED AND SIGNED FORMS TO THE BENEFITS DEPARTMENT		
• By fax to 402-271-2965	• By email to benefits@kiewit.com	• Mail to Kiewit Corporation – Attn: Benefits 1550 Mike Fahey St., Omaha, NE 68102