



Human Resources Department, 9th Floor
451 West Third Street
Dayton, OH 4542

Enrollment Form

(Plan year July 1, 2016 – June 30, 2017)

Submit completed form to:
Fax#: (937) 496-7407
E-mail: HR@MCOHIO.ORG

Personal Information			Hire Date / /		Benefits Effective Date / /					
Last Name		First Name		MI	SS#		Employee#			
E-mail	Home Phone	Work Phone	Legal Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Verify Spouse/Eligible Dependents (Documentation is required to add dependents)					Place an "X" next to those you wish to cover					
Name- Last/First			SS#	DOB	Gender	Legal Relationship	Medical	Dental	Vision	Supp Life

Health Care Options			
Employee Only	Employee + Child(ren)	Employee + Spouse	Family
<input type="checkbox"/> County Plan- \$40.00/month	<input type="checkbox"/> County Plan- \$45.00/month	<input type="checkbox"/> County Plan- \$55.00/month	<input type="checkbox"/> County Plan- \$65.00/month
<input type="checkbox"/> Buy Up Plan- \$195.00/month	<input type="checkbox"/> Buy Up Plan- \$255.00/month	<input type="checkbox"/> Buy Up Plan- \$270.00/month	<input type="checkbox"/> Buy Up Plan- \$330.00/month
<input type="checkbox"/> Advantage Plan- \$25.00/month	<input type="checkbox"/> Advantage Plan- \$30.00/month	<input type="checkbox"/> Advantage Plan- \$35.00/month	<input type="checkbox"/> Advantage Plan- \$45.00/month

Health Care Waiver

I am currently covered on another insurance plan and wish to waive the County Insurance and receive the waiver credit as follows:

Name of subscriber _____ SS# _____ Single \$57.50/month Employee + Spouse \$100.00/month

Insurance Company _____ Plan Policy# _____ Employee + Child(ren) \$90.00/month Family Plan \$120.00/month

I am currently covered by another Montgomery County Employee (Waiver Credit \$0) - Name: _____

I am currently covered by an individual or government-sponsored insurance plan (Waiver Credit \$0)

Dental Plan			
<input type="checkbox"/> Decline Coverage	Employee	Employee + 1 Dependent	Family
	<input type="checkbox"/> Core - \$21.57/month	<input type="checkbox"/> Core - \$43.18/month	<input type="checkbox"/> Core - \$81.42/month
	<input type="checkbox"/> Enhanced - \$31.21/month	<input type="checkbox"/> Enhanced - \$62.52/month	<input type="checkbox"/> Enhanced - \$106.24/month

Vision Plan			
<input type="checkbox"/> Decline Coverage	Employee	Employee + 1 Dependent	Family
	<input type="checkbox"/> \$6.01/month	<input type="checkbox"/> \$12.61/month	<input type="checkbox"/> \$19.22/month

Health Savings Account											
<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> I am eligible	\$ _____ /monthly deduction	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">2017 IRS LIMITS (HSA)</td> </tr> <tr> <td>Employee Only.....</td> <td>\$3,400.00</td> </tr> <tr> <td>Employee + 1 or more.....</td> <td>\$6,750.00</td> </tr> <tr> <td>Age 55 or older – addtl.....</td> <td>\$1,000.00</td> </tr> </table>	2017 IRS LIMITS (HSA)		Employee Only.....	\$3,400.00	Employee + 1 or more.....	\$6,750.00	Age 55 or older – addtl.....	\$1,000.00
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Employee Only.....	\$3,400.00										
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Age 55 or older – addtl.....	\$1,000.00										
			2182 _____ 2183 _____ + _____ <i>Benefits office use only</i>								

Flexible Spending Account									
<input type="checkbox"/> Decline Coverage	Limited FSA (Vision + Dental)	FSA Medical	Dependent Care						
	\$ _____ /month	\$ _____ /month	\$ _____ /month						
			<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">2017 IRS LIMITS (FSA)</td> </tr> <tr> <td>Traditional or Limited.....</td> <td>\$2,600.00</td> </tr> <tr> <td>Dependent Care.....</td> <td>\$5,000.00</td> </tr> </table>	2017 IRS LIMITS (FSA)		Traditional or Limited.....	\$2,600.00	Dependent Care.....	\$5,000.00
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Supplemental Life Insurance			
Decline	Maintain	Add/Increase	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employee Coverage Request _____ (\$10,000 increments)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse Coverage Request _____ (\$5,000 increments)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child(ren) Coverage Request <input type="checkbox"/> \$10,000.00 or <input type="checkbox"/> \$20,000.00
Short-Term Disability			In order to be considered for supplemental life insurance and/or short-term disability, you may be required to satisfactorily demonstrate evidence of insurability requirements and receive approval before plan becomes effective.
<input type="checkbox"/> Decline	<input type="checkbox"/> Accept	<input type="checkbox"/> Maintain	

I understand that this election of benefits cannot be revoked or changed during the plan year **July 1, 2016 – June 30, 2017** unless I have a life event such as marriage, divorce, birth, adoption, etc. In case of a life event, I understand that I must submit proper documentation to substantiate the life event and provide the appropriate dependent documentation to the County HR department within 30 calendar days of a life event in order to make changes to my benefits elections. I authorize my employer to deduct the required amount for the elections I have made above as applicable. I certify that the information given is true and correct to the best of my knowledge. I further understand that failure to remove dependent(s) who subsequently become ineligible within 30 days of the event or false statements could result in legal prosecution and termination of employment. **Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

Signature _____ Date _____

Enrollment form and all required documentation must be submitted within 30 days of hire date or Qualifying Life Event