DDS No Buy up – Department: ____________________ **New Hire** _______ **Life Event** _______ **CHANGE REASON:**________________________

Human Resources Department, 9th Floor
451 West Third Street
Dayton, OH 45422

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:** ☐Single ☐Widowed ☐ Married ☐Separated ☐Divorced	**Sex:** ☐Male ☐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**
☐ County Plan- $40.00/month	☐ County Plan- $45.00/month	☐ County Plan- $55.00/month	☐ County Plan- $65.00/month
☐ Advantage Plan- $25.00/month	☐ Advantage Plan- $30.00/month	☐ Advantage Plan- $35.00/month	☐ 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)**

DDS Dental Plan

	Employee	**Employee + 1 Dependent**	**Family**
☐ Decline Coverage	☐ DDS Core - $14.980/month	☐ DDS Core - $28.42/month	☐ DDS Core - $44.89/month
	☐ DDS Enhanced - $27.00/month	☐ DDS Enhanced - $51.25/month	☐ DDS Enhanced - $86.08/month

Vision Plan

	Employee	**Employee + 1 Dependent**	**Family**
☐ Decline Coverage	☐ $6.01/month	☐ $12.61/month	☐ $19.22/month

Health Savings Account

☐ Decline Coverage ☐ I am eligible

$__________/monthly deduction

2017 IRS LIMITS (HSA)
Employee Only.........................$3,400.00
Employee + 1 or more...............$6,750.00
Age 55 or older – addtl...............$1,000.00

2182____________
2183____________
+____________

Benefits office use only

Flexible Spending Account

☐ Decline Coverage

Limited FSA (Vision + Dental) $______________/month

FSA Medical $__________________/month

Dependent Care $__________________/month

2017 IRS LIMITS (FSA)
Traditional or Limited...............$2,600.00
Dependent Care........................$5,000.00

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