### ### ### ### #### #################	DEPARTMENT	- Public H	lealth W	Vith B	uy up	New Hire	Life	Even	t	_ CH	IANGE	REASO	N:				
Personal Information	451 West Third Street Dayton, OH 45422 Personal Information					(Plan year July 1, 2016 – June 30, 2017) Hire Date / /						Sub	Submit completed form to Fax#: (937) 496-7407 E-mail: HR@MCOHIO.ORG				
Last Name										Benefits Effective Date							
Health Care Options											/ /						
Verify Spouse/Eligible Dependents Status: Separated Divorced	ast Name				First Na	me		MI	SS#				Empl	oyee#			
Verify Spouse/Eligible Dependents (Documentation is required to add dependents) SS# DOB Gender Legal Relationship	-mail		Home P	hone		Work Phone					-			Married	Sex:	□ Male □ Female	
County Plan- \$195.00/month	/erify Spouse	/Eligible I	Depende	ents						— 36	araccu	DIVO	ccu		Place a	n "X" next to	
Health Care Options	Documentation is	s required to)	CC#			OOR.	Condor			Legal P	elationchin		ou wish to cove	
Employee Only	lame- Last/First	ST				33#			ООВ	Geridei	1		Legai N	Celationship		Medical	
Employee Only											1						
Employee Only																	
Employee Only County Plan- \$45.00/month County Plan- \$45.00/month County Plan- \$45.00/month County Plan- \$45.00/month Buy Up Plan- \$255.00/month Buy Up Plan- \$35.00/month Buy Up Plan- \$35.00/month Advantage Plan- \$35.00/month Employee + Spantage Plan- \$35.00/month Advantage Plan- \$35.00/month Ad																	
Employee Only County Plan- \$45.00/month County Plan- \$45.00/month County Plan- \$45.00/month County Plan- \$45.00/month Buy Up Plan- \$255.00/month Buy Up Plan- \$35.00/month Buy Up Plan- \$35.00/month Advantage Plan- \$35.00/month Employee + Spantage Plan- \$35.00/month Advantage Plan- \$35.00/month Ad																	
Employee Only County Plan- \$45.00/month County Plan- \$45.00/month County Plan- \$45.00/month County Plan- \$45.00/month Buy Up Plan- \$255.00/month Buy Up Plan- \$35.00/month Buy Up Plan- \$35.00/month Advantage Plan- \$35.00/month Employee + Spantage Plan- \$35.00/month Advantage Plan- \$35.00/month Ad	aalth Cara	Ontion	-								<u> </u>						
County Plan- \$40.00/month		: Option	15	Em	plovee +	Child(ren)	l e	Emplov	ee + Spou	ise		l F	amily				
Buy Up Plan- \$195.00/month											nth	[County	/ Plan- \$65	.00/mor	nth	
Health Care Waiver I am currently covered on another insurance plan and wish to waive the County Insurance and receive the waiver cre Name of subscriber	☐ Buy Up Plan- \$195.00/month				☐ Buy Up Plan- \$255.00/month			☐ Buy Up Plan- \$270.00/month				☐ Buy Up Plan- \$330.00/month					
I am currently covered on another insurance plan and wish to waive the County Insurance and receive the waiver creation of subscriber	Advantage Plan- \$25.00/month				Advantage	[Advantage Plan- \$35.00/mont				n Advantage Plan- \$45.00/month						
Name of subscriber	ealth Care	Waive	r														
I am currently covered by another Montgomery County Employee (Waiver Credit \$0) - Name: I am current covered under an individual or government-sponsored insurance plan (Waiver Credit \$0) Health Savings Account Decline	I am current	tly covere	d on an	othe	r insuran	ce plan and wish t	to waiv	e the	County I	nsuran	ce and	receive	e the wa	aiver cre	dit as	follows:	
I am currently covered by another Montgomery County Employee (Waiver Credit \$0) - Name: I am current covered under an individual or government-sponsored insurance plan (Waiver Credit \$0) Health Savings Account Decline	Name of subscriber				SS#			Single \$57.50/month □Employee + Spouse \$1								00.00/month	
I am current covered under an individual or government-sponsored insurance plan (Waiver Credit \$0) Health Savings Account	Insurance Company				Plan Policy#			Employee + Child(ren) \$90.0					.00/month Family Plan \$120.00/month				
I am current covered under an individual or government-sponsored insurance plan (Waiver Credit \$0) Health Savings Account Decline	I am currer	ntlv cover	ed by a	nothe	er Monta	omerv County Em	plovee	(Waiv	er Credit	t \$0) -	Name:						
Decline Coverage I am eligible Semployee Loverage Loverage Semployee Loverage	-	-	-		_	-		-))				
Decline Coverage S													<u>, </u>				
Vision Plan Decline Coverage Employee 1 or more \$1,000.00 +		_	1									_					
Vision Plan □ Decline Coverage Employee \$6.01/month □ \$12.61/month □ \$12.61/month □ \$19.22/month understand that this election of benefits cannot be revoked or changed during the plan year July 1, 2016 – June 30, 2017 unless I has marriage, divorce, birth, adoption, etc. In case of a life event, I understand that I must submit proper documentation to substantiate the rovide the appropriate dependent documentation to the County HR department within 30 calendar days of a life event in order to make cenefits elections. I authorize my employer to deduct the required amount for the elections I have made above as applicable. I certify that iven is true and correct to the best of my knowledge. I further understand that failure to remove dependent(s) who subsequently become asys of the event or false statements could result in legal prosecution and termination of employment. Warning: Any person who, with efraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing	a d			5	/monthly deduction			Employee + 1 or more			\$6,750.00			Benefits office use only			
Decline Coverage Employee							Age 55	or olde	r – addtl	\$	1,000.00	+_			usc	Offiy	
understand that this election of benefits cannot be revoked or changed during the plan year July 1, 2016 – June 30, 2017 unless I has marriage, divorce, birth, adoption, etc. In case of a life event, I understand that I must submit proper documentation to substantiate the rovide the appropriate dependent documentation to the County HR department within 30 calendar days of a life event in order to make cenefits elections. I authorize my employer to deduct the required amount for the elections I have made above as applicable. I certify that iven is true and correct to the best of my knowledge. I further understand that failure to remove dependent(s) who subsequently become ays of the event or false statements could result in legal prosecution and termination of employment. Warning: Any person who, witlefraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing	ision Plan			Emm	Novoo		E.	mnlove	o ± 1 Don	ondont		E-	mily				
understand that this election of benefits cannot be revoked or changed during the plan year July 1 , 2016 – June 30 , 2017 unless I has marriage, divorce, birth, adoption, etc. In case of a life event, I understand that I must submit proper documentation to substantiate the rovide the appropriate dependent documentation to the County HR department within 30 calendar days of a life event in order to make cenefits elections. I authorize my employer to deduct the required amount for the elections I have made above as applicable. I certify that iven is true and correct to the best of my knowledge. I further understand that failure to remove dependent(s) who subsequently become ays of the event or false statements could result in legal prosecution and termination of employment. Warning: Any person who, witlefraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing	I I Decline Coverage													/month			
s marriage, divorce, birth, adoption, etc. In case of a life event, I understand that I must submit proper documentation to substantiate the rovide the appropriate dependent documentation to the County HR department within 30 calendar days of a life event in order to make confidence in the confidence in the department within 30 calendar days of a life event in order to make confidence in authorize my employer to deduct the required amount for the elections I have made above as applicable. I certify that iven is true and correct to the best of my knowledge. I further understand that failure to remove dependent(s) who subsequently become lays of the event or false statements could result in legal prosecution and termination of employment. Warning: Any person who, witlefraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing	derstand that t	this election	of hence				durina t			v 1 20	16 – Iı				ve a life	e event such	
	narriage, divoro vide the approp efits elections. I en is true and co s of the event o raud or know	ce, birth, ac oriate deper I authorize orrect to th or false stat ving that h	doption, on the domination of	etc. In cumer bloyer f my k could s facil	n case of a ntation to to deduct nowledge result in la litating a	a life event, I unders the County HR depa the required amoun . I further understar egal prosecution and a fraud against an	stand that artment at for the and that f d termin	at I mu within e electi failure ation c	ust submit 30 calend ions I have to remove of employn	proper ar days e made depend nent. W	docume of a life above a dent(s) v	entation e event in as applications who sub e: Any p	to substan order t able. I ca sequentl erson w	antiate the o make chertify that become vho, with	e life eve nanges the inf ineligi inten	vent and to my formation ble within 30 t to	

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

Date

Signature