

Human Resources Department, 9 th Floor 451 West Third Street Dayton, OH 45422		<h2 style="margin: 0;">Enrollment Form</h2> (Plan year July 1, 2016 – June 30, 2017)			Submit completed form to: Fax#: (937) 496-7407 E-mail: HR@MCOHIO.ORG	
		Hire Date / /		Benefits Effective Date / /		
Personal Information						
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) Name- Last/First			SS#	DOB	Gender	Legal Relationship Medical

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

Health Care Waiver	
<input type="checkbox"/> 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# _____ <input type="checkbox"/> Single \$57.50/month <input type="checkbox"/> Employee + Spouse \$100.00/month Insurance Company _____ Plan Policy# _____ <input type="checkbox"/> Employee + Child(ren) \$90.00/month <input type="checkbox"/> Family Plan \$120.00/month	
<input type="checkbox"/> I am currently covered by another Montgomery County Employee (Waiver Credit \$0) - Name: _____	
<input type="checkbox"/> I am current covered under an individual or government-sponsored insurance plan (Waiver Credit \$0)	

Health Savings Account			
<input type="checkbox"/> Decline Coverage <input type="checkbox"/> 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 _____ + _____ <i>Benefits office use only</i>

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

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