



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 <input type="checkbox"/> County Plan- \$40.00/month <input type="checkbox"/> Advantage Plan- \$25.00/month	Employee + Child(ren) <input type="checkbox"/> County Plan- \$45.00/month <input type="checkbox"/> Advantage Plan- \$30.00/month	Employee + Spouse <input type="checkbox"/> County Plan- \$55.00/month <input type="checkbox"/> Advantage Plan- \$35.00/month	Family <input type="checkbox"/> County Plan- \$65.00/month <input type="checkbox"/> Advantage Plan- \$45.00/month

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

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

Health Savings Account			
<input type="checkbox"/> Decline Coverage <input type="checkbox"/> I am eligible	\$ _____/monthly deduction	2016 IRS LIMITS (HSA) Employee Only.....\$3,350.00 Employee + 1 or more.....\$6,650.00 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) \$ _____/month	FSA Medical \$ _____/month	Dependent Care \$ _____/month
			2016 IRS LIMITS (FSA) Traditional or Limited.....\$2,550.00 Dependent Care.....\$5,000.00

Supplemental Life Insurance			
Decline <input type="checkbox"/> Maintain <input type="checkbox"/> Add/Increase <input type="checkbox"/>	Employee Coverage Request _____ (\$10,000 increments) Spouse Coverage Request _____ (\$5,000 increments) Child(ren) Coverage Request <input type="checkbox"/> \$10,000.00 or <input type="checkbox"/> \$20,000.00	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.	

Short-Term Disability		
<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