

	Human Resources Department, 9 <sup>th</sup> Floor 451 West Third Street Dayton, OH 4542	<h2 style="margin:0;">Enrollment Form</h2> <p style="margin:0;">(Plan year July 1, 2017 – June 30, 2018)</p>	Submit completed form to: Fax#: (937) 496-7407 E-mail: HR@MCOHIO.ORG
<b>Personal Information</b>		<b>Hire Date</b> / /	<b>Benefits Effective Date</b> / /
<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>SS#</b>
<b>E-mail</b>	<b>Home Phone</b>	<b>Work Phone</b>	<b>Legal Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
			<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Verify Spouse/Eligible Dependents</b> (Documentation is required to add dependents)			Place an "X" next to those you wish to cover Supp Life
Name- Last/First		SS#	DOB
			Gender
			Legal Relationship
			Medical
			Dental
			Vision
			Supp Life
<b>Health Care Options</b>			
<u>Employee Only</u>		<u>Employee + Child(ren)</u>	
<input type="checkbox"/> County Plan- \$40.00/month		<input type="checkbox"/> County Plan- \$45.00/month	
<input type="checkbox"/> Advantage Plan- \$25.00/month		<input type="checkbox"/> Advantage Plan- \$30.00/month	
<u>Employee + Spouse</u>		<u>Family</u>	
<input type="checkbox"/> County Plan- \$55.00/month		<input type="checkbox"/> County Plan- \$65.00/month	
<input type="checkbox"/> Advantage Plan- \$35.00/month		<input type="checkbox"/> Advantage Plan- \$45.00/month	
<b>Health Care Waiver</b>			
<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 currently covered by an individual or government-sponsored insurance plan (Waiver Credit \$0)			
<b>Dental Plan</b>			
<input type="checkbox"/> Decline Coverage		<u>Employee</u>	
		<input type="checkbox"/> Core - \$23.36/month	
		<input type="checkbox"/> Enhanced - \$33.83/month	
		<u>Employee + 1 Dependent</u>	
		<input type="checkbox"/> Core - \$46.73/month	
		<input type="checkbox"/> Enhanced - \$67.65/month	
		<u>Family</u>	
		<input type="checkbox"/> Core - \$88.12/month	
		<input type="checkbox"/> Enhanced - \$114.97/month	
<b>Vision Plan</b>			
<input type="checkbox"/> Decline Coverage		<u>Employee</u>	
		<input type="checkbox"/> \$6.01/month	
		<u>Employee + 1 Dependent</u>	
		<input type="checkbox"/> \$12.61/month	
		<u>Family</u>	
		<input type="checkbox"/> \$19.22/month	
<b>Health Savings Account</b>			
<input type="checkbox"/> Decline Coverage <input type="checkbox"/> I am eligible		2018 IRS LIMITS (HSA) Employee Only.....\$3,450.00 Employee + 1 or more.....\$6,850.00 Age 55 or older – addtl.....\$1,000.00	
\$ _____/monthly deduction		2182 _____ 2183 _____ <i>Benefits office use only</i> + _____	
<b>Flexible Spending Account</b>			
<input type="checkbox"/> Decline Coverage		<u>Limited FSA</u> (Vision + Dental)	
\$ _____/month		<u>FSA Medical</u>	
		\$ _____/month	
		<u>Dependent Care</u>	
		\$ _____/month	
		2018 IRS LIMITS (FSA) Traditional or Limited.....\$2,650.00 Dependent Care.....\$5,000.00	
<b>Supplemental Life Insurance</b>			
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
			<b>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.</b>

I understand that this election of benefits cannot be revoked or changed during the plan year **July 1, 2017 – June 30, 2018** 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**