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, 2017 – June 30, 2018)

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:	Sex:
			☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced	☐ Male ☐ Female

Verify Spouse/Eligible Dependents (Documentation is required to add dependents) Name- Last/First	SS#	DOB	Gender	Legal Relationship	Place an "X" next to those you wish to cover: 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

☐ Decline Coverage	Employee	Employee + 1 Dependent	Family
	☐ DDS Core - $16.88/month	☐ DDS Core - $31.92/month	☐ DDS Core - $50.40/month
	☐ DDS Enhanced - $29.40/month	☐ DDS Enhanced - $55.56/month	☐ DDS Enhanced - $93.28/month

Vision Plan

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

Health Savings Account

☐ Decline Coverage ☐ I am eligible

$_____/monthly deduction

2018 IRS LIMITS (HSA)
Employee Only.....$3,450.00
Employee + 1 or more.....$6,850.00
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

2018 IRS LIMITS (FSA)
Traditional or Limited.....$2,650.00
Dependent Care.....$5,000.00

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