



Human Resources
Department
9th Floor
451 West Third Street
Dayton, OH 4542

Enrollment Form

(Plan Year Jan. 1, 2023 – Dec. 31, 2023)

Submit completed form to:
Email: HR@MCOHIO.ORG

Personal Information		Hire Date			Benefit Effective Date										
		/ /			/ /										
Last Name	First Name	MI	SSN	Employee#											
Phone		E-mail													
Spouse/Eligible Dependents (Documentation required)		Social Security #		Date of Birth		Gender		Legal Relationship		Mark coverage with X					
Name- Last/First										Medical	Dental	Vision	Supp Life		

Health Care Options			
<p>Employee Only</p> <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	<p>Employee + Child(ren)</p> <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	<p>Employee + Spouse/Family</p> <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	<p>Waiver (Proof of other coverage required)</p> <input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Other Gov Coverage Waiver <input type="checkbox"/> Other Mont. Co. Coverage

Dental Plan			
<input type="checkbox"/> Decline Coverage	<p>Employee</p> <input type="checkbox"/> Core <input type="checkbox"/> Enhanced	<p>Employee + 1 Dependent</p> <input type="checkbox"/> Core <input type="checkbox"/> Enhanced	<p>Family</p> <input type="checkbox"/> Core <input type="checkbox"/> Enhanced

Vision Plan			
<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee + 1 Dependent	<input type="checkbox"/> Family

Health Savings Account*			
<input type="checkbox"/> Decline <input type="checkbox"/> Add/Maintain	\$ _____ /month	<p><small>*I confirm that it is my intention to open a Health Savings Account with Optum Bank, and my signature below is my agreement to be bound by the terms and conditions set forth by Optum Bank.</small></p>	2190 _____ 2195 _____ <i>Benefits office use only</i> + _____

Flexible Spending Account			
<input type="checkbox"/> Decline	<p>Limited FSA (Vision + Dental)</p> \$ _____ /month	<p>FSA Medical</p> \$ _____ /month	<p>Dependent Care</p> \$ _____ /month
			2369 _____ <i>Benefits office use only</i> 2372 _____

Supplemental Life Insurance			
Decline	Maintain	Add/Increase	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

Short-Term Disability		
<input type="checkbox"/> Decline	<input type="checkbox"/> Accept	<input type="checkbox"/> Maintain

You may be required to complete an evidence of insurability (EOI) and receive approval before plan becomes effective.

I understand that this election of benefits cannot be revoked or changed during the plan year unless I have a qualifying life event. 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