

	Human Resources Department 9 th Floor 451 West Third Street Dayton, OH 4542	<h2 style="margin:0;">Enrollment Form</h2> <p style="margin:0;">(Plan Year Jan. 1, 2023 – Dec. 31, 2023)</p>	Submit completed form to: Email: HR@MCOHIO.ORG
Personal Information		Hire Date / /	Benefit Effective Date / /
Last Name	First Name	MI	SSN
Phone		E-mail	
Spouse/Eligible Dependents (Documentation required)			
Name- Last/First	Social Security #	Date of Birth	Gender
Health Care Options			
Employee Only <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	Employee + Child(ren) <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	Employee + Spouse/Family <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	Waiver (Proof of other coverage required) <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
Health Savings Account*			
<input type="checkbox"/> Decline <input type="checkbox"/> Add/Maintain	\$ _____/month	*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.	2190 _____ 2195 _____ <i>Benefits office use only</i> + _____
Flexible Spending Account			
<input type="checkbox"/> Decline Limited FSA (Vision + Dental)	\$ _____/month	FSA Medical	\$ _____/month
		Dependent Care	\$ _____/month
			2369 _____ 2372 _____ <i>Benefits office use only</i>
Supplemental Life Insurance			
Decline Maintain Add/Increase <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Employee Coverage Request _____ (\$10,000 increments)	You may be required to complete an evidence of insurability (EOI) and receive approval before plan becomes effective.	
<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		

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