Department __**Public Health**__ **New Hire** ________ **Life Event** ________ **CHANGE REASON:**____________________________

MONTGOMERY COUNTY
Human Resources Department, 9th Floor
451 West Third Street
Dayton, OH 45422

Enrollment Form

(Plan year July 1, 2018 – June 30, 2019)

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

Health Care Options

Employee Only	Employee + Child(ren)	Employee + Spouse	Family
☐ Basic Plan	☐ Basic Plan	☐ Basic Plan	☐ Basic Plan
☐ Enhanced Plan	☐ Enhanced Plan	☐ Enhanced Plan	☐ Enhanced Plan

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 ☐ Employee + Spouse

Insurance Company ____________________ Plan Policy# _____________ ☐ Employee + Child(ren) ☐ Family Plan

☐ **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)**

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*

Vision Plan

☐ Decline Coverage ☐ Employee ☐ Employee + 1 Dependent ☐ Family

I understand that this election of benefits cannot be revoked or changed during the plan year **July 1, 2018 – June 30, 2019** 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