Department: ____________________ **New Hire** _______ **Life Event** _______ **CHANGE REASON:**______________________

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

Enrollment Form

(Plan Year Jan. 1, 2021 – Dec. 31, 2021)

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#

Work Phone	Home Phone	E-mail

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
☐ Basic Plan
☐ Enhanced Plan

Employee + Child(ren)
☐ Basic Plan
☐ Enhanced Plan

Employee + Spouse/Family
☐ Basic Plan
☐ Enhanced Plan

Waiver
☐ Employee Only ☐ EE + Spouse
☐ EE + Child(ren) ☐ Family
☐ Government Waiver
☐ Mont. Co. Married Waiver
(Proof of other coverage must be attached)

Dental Plan

☐ Decline Coverage

Employee
☐ Core
☐ Enhanced

Employee + 1 Dependent
☐ Core
☐ Enhanced

Family
☐ Core
☐ Enhanced

Vision Plan

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

Health Savings Account

☐ Decline Coverage ☐ I am eligible

$__________/monthly deduction

2021 IRS LIMITS (HSA)
Employee Only........................$3,600.00
Employee + 1 or more..............$7,200.00
Age 55 or older – addtl..............$1,000.00

2190______________
2195______________
+______________

Benefits office use only

Flexible Spending Account

☐ Decline Coverage

Limited FSA (Vision + Dental) $_______________/month

FSA Medical $_________________/month

Dependent Care $_________________/month

2021 IRS LIMITS (FSA)
Traditional or Limited...............$2,750.00
Dependent Care........................$5,000.00

Supplemental Life Insurance

Decline	Maintain	Add/Increase		
☐	☐	☐	Employee	Coverage Request _______________($10,000 increments)
☐	☐	☐	Spouse	Coverage Request _______________($5,000 increments)
☐	☐	☐	Child(ren)	Coverage Request ☐ $10,000.00 or ☐ $20,000.00

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.

Short-Term Disability

☐ Decline ☐ Accept ☐ Maintain

I understand that this election of benefits cannot be revoked or changed during the plan year **Jan. 1, 2021 – Dec. 31, 2021** 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