



Human Resources  
Department  
9<sup>th</sup> 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](mailto: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><b>Employee Only</b></p> <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	<p><b>Employee + Child(ren)</b></p> <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	<p><b>Employee + Spouse/Family</b></p> <input type="checkbox"/> Basic Plan <input type="checkbox"/> Enhanced Plan	<p><b>Waiver</b> (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><b>Employee</b></p> <input type="checkbox"/> Core <input type="checkbox"/> Enhanced	<p><b>Employee + 1 Dependent</b></p> <input type="checkbox"/> Core <input type="checkbox"/> Enhanced	<p><b>Family</b></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><b>Limited FSA</b> (Vision + Dental)</p> \$ _____/month	<p><b>FSA Medical</b></p> \$ _____/month	<p><b>Dependent Care</b></p> \$ _____/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"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Employee Spouse Child(ren)	Coverage Request _____ (\$10,000 increments) Coverage Request _____ (\$5,000 increments) Coverage Request <input type="checkbox"/> \$10,000.00 or <input type="checkbox"/> \$20,000.00	<p><b>You may be required to complete an evidence of insurability (EOI) and receive approval before plan becomes effective.</b></p>

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**