Department: DDS **New Hire** _____ **Life Event** _____ **CHANGE REASON:** _____

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) Name- Last/First	Social Security #	Date of Birth	Gender	Legal Relationship	Mark coverage with X Medical	Dental	Vision

Health Care Options

Employee Only	Employee + Child(ren)	Employee + Spouse/Family	Waiver (Proof of other coverage required)
☐ Basic Plan	☐ Basic Plan	☐ Basic Plan	☐ Employee Only ☐ EE + Spouse
☐ Enhanced Plan	☐ Enhanced Plan	☐ Enhanced Plan	☐ EE + Child(ren) ☐ Family
			☐ Other Gov Coverage Waiver
			☐ Other Mont. Co. Coverage

Dental Plan

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

Vision Plan

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

Health Savings Account*

☐ Decline ☐ 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 _____
\+ _____
Benefits office use only

Flexible Spending Account

☐ Decline

Limited FSA (Vision + Dental) $_____/month

FSA Medical $_____/month

Dependent Care $_____/month

2369 _____
2372 _____
Benefits office use only

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

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

GO TO WWW.MCBENEFITS.ORG FOR LIFE EVENT, DEPENDENT AND BENEFITS INFORMATION