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

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

Enrollment Form

(Plan year July 1, 2020 – Dec. 31, 2020)

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	Dental	Vision	Supp Life

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 $57.50/month ☐ Employee + Spouse $100.00/month

Insurance Company _____ Plan Policy# _____ ☐ Employee + Child(ren) $90.00/month ☐ Family Plan $120.00/month

☐ **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

2020 IRS LIMITS (HSA)
Employee Only.....$3,550.00
Employee + 1 or more.....$7,100.00
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

2020 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.

I understand that this election of benefits cannot be revoked or changed during the plan year **July 1, 2020 – Dec. 31, 2020** 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

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