2025 HUMAN RESOURCES BENEFITS ENROLLMENT FORM

SECTION 1: EMPLOYEE INFORMATION			
LAST NAME, FIRST, MI.	SOCIAL SECURITY NUMBER		DATE OF BIRTH
STREET ADDRESS	DATE OF HIRE		MARITAL STATUS
CITY	STATE	ZIP CODE	GENDER
EMAIL ADDRESS		PHONE NUMBER	
AGENCY NAME	UNION NAME (IF APPLICABLE)		EMPLOYEE NUMBER

SECTION 2: BENEFITS ENROLLMENT			
CHECK BOX BELOW	MEDICAL PLAN OPTIONS	CHECK BOX BELOW	DENTAL PLAN OPTIONS
	EMPLOYEE ONLY		EMPLOYEE ONLY
	FAMILY		FAMILY
	WAIVE COVERAGE (NO MEDICAL PLAN)		WAIVE COVERAGE (NO DENTAL PLAN)
CHECK BOX BELOW	MEDICAL PLANS	CHECK BOX BELOW	DENTAL PLANS
	METROHEALTH HIGH DEDUCTIBLE PLAN		AFSCME CARE PLAN (AFSCME EMPLOYEES ONLY)
	SKYWAY PLAN (formerly MetroHealth Select)		DELTA DENTAL PLAN
	MEDICAL MUTUAL SUPERMED EPO PLAN		
	MEDICAL MUTUAL SUPERMED PPO PLAN		
CHECK BOX BELOW	VISION PLAN OPTIONS	ENTER ANNUAL DOLLAR AMOUNT BELOW	FLEXIBLE SPENDING ACCOUNTS
	EMPLOYEE ONLY		MEDICAL FLEXIBLE SPENDING ACCOUNT
	FAMILY		DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT
	WAIVE COVERAGE (NO VISION PLAN)		
CHECK BOX BELOW	VISION PLAN	CHECK BOX BELOW IF WAIVING FSA	WAIVE FLEXIBLE SPENDING ACCOUNT(S)
	AFSCME CARE PLAN (AFSCME EMPLOYEES ONLY)		WAIVE MEDICAL FSA (NO MEDICAL FSA)
	VSP VISION PLAN		WAIVE DEPENDENT CARE FSA (NO DEPENDENT CARE FSA)

SUPPLEMENTAL GROUP TERM LIFE INSURANCE - PLEASE ENTER THE SUPPLEMENTAL LIFE INSURANCE COVERAGE AMOUNT YOU WANT TO ELECT IN A $10,000 INCREMENT UP TO $500,000 MAXIMUM UNLESS YOU ARE IN UNIONS 27, 1746, OR 2927 SKIP TO ASFCME LIFE INSURANCE SECTION.

ENTER COVERAGE AMOUNT	

THE COUNTY PROVIDES DEPENDENT LIFE INSURANCE - $1,000 SPOUSE/$500 UNMARRIED DEPENDENT CHILD(REN) UNDER AGE 26. PLEASE ANSWER THE QUESTION BELOW UNLESS YOU ARE IN UNIONS 27, 1746 OR 2927 THEN SKIP TO NEXT SECTION.

DO YOU HAVE A LEGAL SPOUSE? (CIRCLE YES OR NO TO THE RIGHT)	YES	NO		DO YOU HAVE UNMARRIED DEPENDENT CHILD(REN) AGE 26 AND UNDER? (CIRLCLE YES OR NO TO THE RIGHT)	YES	NO

AFSCME LIFE INSURANCE (UNIONS 27, 1746 AND 2927 ONLY) - PLEASE ENTER THE AMOUNT OF SUPPLEMENTAL LIFE INSURANCE COVERAGE AMOUNT YOU WANT TO ELECT IN A $10,000 INCREMENT UP TO $500,000 MAXIMUM.	
ENTER COVERAGE AMOUNT	

SECTION 3: PROOF OF ALTERNATIVE COVERAGE: THIS SECTION MUST BE COMPLETED IF WAIVING COVERAGE. YOU MUST HAVE ALTERNATE COVERAGE TO RECEIVE THE BENEFITS ALLOWANCE/TAXABLE OPT-OUT PAYMENT (See Section 10.01 of the Employee Handbook).

ARE YOU COVERED BY A NON-COUNTY MEDICAL PLAN? (CIRCLE YES OR NO TO THE RIGHT)	YES	NO		ARE YOU COVERED BY A NON-COUNTY DENTAL PLAN? (CIRCLE YES OR NO TO THE RIGHT)	YES	NO
ARE YOU COVERED BY A COUNTY MEDICAL PLAN THROUGH ANOTHER CUYAHOGA COUNTY EMPLOYEE? (CIRCLE YES OR NO TO THE RIGHT)					YES	NO
ARE YOU COVERED BY A COUNTY DENTAL PLAN THROUGH ANOTHER CUYAHOGA COUNTY EMPLOYEE? (CIRCLE YES OR NO TO THE RIGHT)					YES	NO

SECTION 4: DEPENDENT INFORMATION (COMPLETE WHEN ENROLLING YOUR DEPENDENTS IN MEDICAL, DENTAL, VISION, DEPENDENT LIFE AND/OR FLEXIBLE SPENDING ACCOUNTS COVERAGE).

LAST NAME, FIRST, MI.	RELATIONSHIP	GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER

SECTION 5: EMPLOYEE AUTHORIZATION - THIS FORM MUST BE SIGNED FOR ENROLLMENT TO BE COMPLETE.

I attest that the information provided is accurate. I understand that if there is any change in status or qualifying life event (i.e. change in dependent eligibility, loss or gain of coverage, marriage, divorce, etc.) for me or my dependent(s) listed on this enrollment, I am responsible for notifying Cuyahoga County within 30 consecutive calendar days of such change. I understand that if I submit false information intended to provide coverage for alleged dependent(s) not eligible for such coverage, I may be subject to corrective action up to including disciplinary removal. Also, I may be held financially responsible for all claims filed and be required to reimburse Cuyahoga County for any payments made on behalf of or for the benefit of an ineligible person claimed as a dependent.

Enrollment is not complete until verification of the dependent(s) eligibility is successful. I understand that if I am applying to add a new dependent(s) to my coverage, I must provide copies of proof of relationship documents to verify my dependent(s) eligibility within Cuyahoga County's specified enrollment timelines, or the dependent(s) will not be enrolled.

Employees who have waived coverage through Cuyahoga County may be entitled to receive a Benefits Allowance/Taxable Opt-Out Payment but are required to attest that they have alternative medical and/or dental coverage to receive it.

I hereby authorize payroll deductions from my salary for the amount required, if any, for the insurance indicated. This authorization will be in effect unless I experience a qualifying life event and notify Cuyahoga County within 30 consecutive calendar days of such event. Employee contributions for benefits are paid through a pre-tax payroll deduction.

SIGNATURE	DATE

CUYAHOGA COUNTY HUMAN RESOURCES EMPLOYEE BENEFITS ONLY

BENEFITS EFFECTIVE DATE	DATE ENTERED IN GHR	COBRA NOTIFICATION DATE