

2023 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 PER PAY 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	
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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? (CIRCLE YES OR NO TO THE RIGHT)	YES	NO
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