2023 HUMAN RESOURCES EMPLOYEE BENEFITS OFFICE CHANGE/ENROLLMENT FORM

Reason for Completing Form

SECTION 1: CURRENT/PREVIOUS EMPLOYEE INFORMATION (Complete in full before other sections of this form.)

LAST NAME, FIRST, MI.	SOCIAL SECURITY NUMBER	DATE OF BIRTH
STREET ADDRESS	DATE OF HIRE	MARITAL STATUS
CITY STATE ZIP	AGENCY NAME & NUMBER	UNION NAME
EMAIL ADDRESS PHONE NUMBER	EMPLOYEE NUMBER	GENDER

SECTION 2: CHANGED/NEW EMPLOYEE INFORMATION (Only complete applicable information).

LAST NAME, FIRST, MI.	MARITAL STATUS *(DOCUMENTATION REQUIRED)*	
STREET ADDRESS	AGENCY NAME & NUMBER	UNION NAME
CITY STATE ZIP	EMAIL ADDRESS	PHONE NUMBER

SECTION 3: EMPLOYMENT STATUS

CURRENT		CHANGE TO
	NEW HIRE	
	FULLTIME (min. 30 hrs/week)	
	PART TIME (20-29 hrs/week)	
	MINIMUM TIME (less than 20 hrs/week)	
	NOT COVERED BY BARGAINING UNIT	
	COVERED BY BARGAINING UNIT	
	COVERED BY AFSCME	
	FMLA DAYS REMAINING	
	MEDICAL LEAVE	
	MILITARY LEAVE	
	OTHER LEAVE W/O PAY	
	LAYOFF	
	AWOL	
	INVOLUNTARY TERMINATION	
	DISABILITY SEPARATION	
	RESIGNED	
	RETIRED	
	DECEASED	

TRANSFER FROM _____ **TO** _____

DATE OF HIRE: _____

EFFECTIVE DATE OF CHANGE: _____

EFFECTIVE DATE OF COVERAGE _____

SECTION 4: BENEFITS ENROLLMENT

MEDICAL PLAN OPTIONS

CURRENT		CHANGE TO
	EMPLOYEE ONLY	
	FAMILY	
	WAIVE COVERAGE (NO MEDICAL PLAN)	
	METROHEALTH SELECT HIGH DEDUCTIBLE PLAN	
	METROHEALTH SELECT PLAN	
	MEDICAL MUTUAL SUPERMED EPO PLAN	
	MEDICAL MUTUAL SUPERMED PPO PLAN	

DENTAL PLAN OPTIONS

CURRENT		CHANGE TO
	EMPLOYEE ONLY	
	FAMILY	
	WAIVE COVERAGE (NO DENTAL PLAN)	
	AFSCME CARE PLAN (For AFSCME Employees ONLY)	
	DELTA DENTAL PLAN	

VISION PLAN OPTIONS

CURRENT		CHANGE TO
	EMPLOYEE ONLY	
	FAMILY	
	WAIVE COVERAGE (NO VISION PLAN)	
	AFSCME CARE PLAN (For AFSCME Employees ONLY)	
	VSP VISION PLAN	

FLEXIBLE SPENDING ACCOUNTS

BIWEEKLY PAYROLL DEDUCTION

CURRENT		CHANGE TO
	MEDICAL FLEXIBLE SPENDING ACCOUNT	
	WAIVE MEDICAL FLEXIBLE SPENDING ACCOUNT	

			DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT	
			WAIVE DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT	
CANCELLATION DATE:				

SUPPLEMENTAL GROUP TERM LIFE INSURANCE FOR NON-AFSCME EMPLOYEES		SUPPLEMENTAL GROUP TERM LIFE INSURANCE FOR AFSCME EMPLOYEES: (UNION 27, UNION 1746 AND UNION 2927 ONLY)	
Please enter the amount of Supplemental Life Insurance you wish to elect below in $10,0000 increments up to $500,000 maximum.		Please enter the amount of Supplemental Life Insurance you wish to elect below in $10,0000 increments up to $500,000 maximum.	
CURRENT	CHANGE TO	CURRENT	CHANGE TO

Dependent Life Insurance Option - $1,000 Spouse/$500 Dependent Unmarried Child(ren) under age 26, unless disabled (Except AFSCME Union 27, Union 1746, and Union 2927) - Please circle the answer to the question below

Do you have a legal spouse and or unmarried dependent child(ren) age 26 and below? Yes or No

SECTION 5: THIS SECTION MUST BE COMPLETED IF WAIVING COVERAGE. PROOF OF ALTERNATIVE 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 UNDER ANOTHER MEDICAL PLAN? (CIRCLE YES OR NO TO THE RIGHT)	YES	NO		ARE YOU COVERED UNDER ANOTHER DENTAL PLAN? (CIRCLE YES OR NO TO THE RIGHT)	YES	NO
ARE YOU COVERED BY A COUNTY BENEFITS PLAN THROUGH ANOTHER CUYAHOGA COUNTY EMPLOYEE? (CIRCLE YES OR NO TO THE RIGHT)					YES	NO

SECTION 6: DEPENDENT INFORMATION (COMPLETE WHEN ENROLLING YOUR DEPENDENTS IN MEDICAL, DENTAL, VISION, DEPENDENT LIFE AND/OR FLEXIBLE SPENDING ACCOUNTS COVERAGE).

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

*ALL INFORMATION MUST BE COMPLETED AND REQUIRED DOCUMENTATION MUST BE SUBMITTED WITH BENEFITS ENROLLMENT FORM.

SECTION 7: 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 dependents 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 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

HUMAN RESOURCES OFFICE USE ONLY

HOURLY RATE

CUYAHOGA COUNTY HUMAN RESOURCES EMPLOYEE BENEFITS ONLY

Requirements to Process Enrollment:				
Signature on Form Above			EOI Submitted to MedMutual Life	
Marriage Certificate Required to Add Spouse			Date Entered in GHR	

Birth Certificate(s) Required for Dependent(s)			Retro Adjustment	
Complete & Signed Beneficiary Form			COBRA Notification Date	

10/13/2022