



A. Employee General Information:

First Name: _____ Employee ID: _____ DOB: _____
 Last Name: _____ Department #: _____
 Home Phone: (____) _____ - _____ Email Address: _____
 Street Address: _____
Street address City State Zip Code

B. Dependent Information: *Supporting documentation is required when adding dependents.*

Complete this section when adding a dependent to your medical, dental, and/or vision election.
If you are adding a dependent to supplemental life insurance coverage, please note that proof of FT student status does not need to be submitted at this time, however, a claim will not get paid unless the dependent is a FT student.

Spouse	Documentation Included for Spouse							
Name: _____ Date of Birth: ____-____-____ Gender: M or F <table border="1" style="margin-top: 10px;"> <tr><td>Medical</td><td><input type="checkbox"/></td></tr> <tr><td>Dental</td><td><input type="checkbox"/></td></tr> <tr><td>Vision</td><td><input type="checkbox"/></td></tr> </table>	Medical	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/> Copy of marriage license or certificate. AND <input type="checkbox"/> Copy of first page of most recent tax return (The dollar amounts can be marked out). You will not need to provide a tax return if you are newly married in 2016.	HR Use Only
Medical	<input type="checkbox"/>							
Dental	<input type="checkbox"/>							
Vision	<input type="checkbox"/>							

Dependent Child 1	Documentation Included for Dependent Child 1							
Name: _____ Date of Birth: ____-____-____ Gender: M or F Dependent a full-time student? Yes <input type="checkbox"/> No <input type="checkbox"/> <table border="1" style="margin-top: 10px;"> <tr><td>Medical</td><td><input type="checkbox"/></td></tr> <tr><td>Dental</td><td><input type="checkbox"/></td></tr> <tr><td>Vision</td><td><input type="checkbox"/></td></tr> </table>	Medical	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/> Copy of birth certificate/adoption paperwork/court order <input type="checkbox"/> (If applicable) Copy of Social Security or physician certification of disability	HR Use Only
Medical	<input type="checkbox"/>							
Dental	<input type="checkbox"/>							
Vision	<input type="checkbox"/>							

Dependent Child 2	Documentation Included for Dependent Child 2							
Name: _____ Date of Birth: ____-____-____ Gender: M or F Dependent a full-time student? Yes <input type="checkbox"/> No <input type="checkbox"/> <table border="1" style="margin-top: 10px;"> <tr><td>Medical</td><td><input type="checkbox"/></td></tr> <tr><td>Dental</td><td><input type="checkbox"/></td></tr> <tr><td>Vision</td><td><input type="checkbox"/></td></tr> </table>	Medical	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/> Copy of birth certificate/adoption paperwork/court order <input type="checkbox"/> (If applicable) Copy of Social Security or physician certification of disability	HR Use Only
Medical	<input type="checkbox"/>							
Dental	<input type="checkbox"/>							
Vision	<input type="checkbox"/>							

Dependent Child 3	Documentation Included for Dependent Child 3	HR Use Only						
Name: _____ Date of Birth: ____-____-____ Gender: M or F Dependent a full-time student? Yes <input type="checkbox"/> No <input type="checkbox"/> <table border="1" style="width: 100px; margin-top: 10px;"> <tr><td>Medical</td><td><input type="checkbox"/></td></tr> <tr><td>Dental</td><td><input type="checkbox"/></td></tr> <tr><td>Vision</td><td><input type="checkbox"/></td></tr> </table>	Medical	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/> Copy of birth certificate/adoption paperwork/court order <input type="checkbox"/> (If applicable) Copy of Social Security or physician certification of disability	
Medical	<input type="checkbox"/>							
Dental	<input type="checkbox"/>							
Vision	<input type="checkbox"/>							

Dependent Child 4	Documentation Included for Dependent Child 4	HR Use Only						
Name: _____ Date of Birth: ____-____-____ Gender: M or F Dependent a full-time student? Yes <input type="checkbox"/> No <input type="checkbox"/> <table border="1" style="width: 100px; margin-top: 10px;"> <tr><td>Medical</td><td><input type="checkbox"/></td></tr> <tr><td>Dental</td><td><input type="checkbox"/></td></tr> <tr><td>Vision</td><td><input type="checkbox"/></td></tr> </table>	Medical	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/> Copy of birth certificate/adoption paperwork/court order <input type="checkbox"/> (If applicable) Copy of Social Security or physician certification of disability	
Medical	<input type="checkbox"/>							
Dental	<input type="checkbox"/>							
Vision	<input type="checkbox"/>							

C. Authorization:

I have read and understand all eligibility requirements set forth by Hamilton County. I have been informed of my benefit options and costs. I agree to pay required contributions, if applicable, through payroll deductions. I understand that I may only change my elections if I have a qualifying event and that only changes consistent with that event are allowed. I understand that I must notify my department payroll representative of my qualifying event within 31 days of the event or I may not make any changes. My signature below indicates the information set forth on this form is true and complete to the best of my knowledge. Any false statements on this form shall be considered grounds for discipline, up to and including termination.

Signature: _____

Date: _____

HR USE ONLY:	
HRP:	_____
Deductions:	_____
Scanned:	_____