

**LOGAN COUNTY
INSURANCE ENROLLMENT FORM**
For new enrollments and enrollment changes

PLEASE READ COMPLETELY

DEPARTMENT NAME

Employee Information:

LAST NAME

FIRST NAME

MIDDLE

Social Security Number

Please choose ONE option from below:

PPO 4a

SINGLE @\$76 MOS.

FAMILY @\$191 MOS.

Ohio Adult Dependant

(Unmarried Child ages 26 through 27)

\$275.89/MOS.

of Adult Dependents:

(Premium charged for EACH adult dependant)

**deductions divided by two paychecks per month*

If you wish to enroll in family coverage and currently have a single policy (or vice versa), a new CEBCO application must be completed. Except for annual open enrollment, no additions may be made without a qualifying event, which may be subject to medical underwriting and may possibly be denied by the insurance carrier.

By signing below I authorize the Logan County Auditor to take the above deductions from my regular pay. In the event a pay deduction is not taken from my regular pay, I agree to make payment by cash or check for the required deduction amount upon notification by the Logan County Commissioners office. I authorize Logan County to change my health insurance deduction amount at each annual open enrollment to the amount established by the Board of Logan County Commissioners for the plan option(s) I have selected above.

Employee Signature

Date