Office Use Only
Submitted Effective Date: _____

Age-In Selection Form

Please return this form with a copy of your Medicare card.

Member Information

Primary Retiree Name: _____

Primary Retiree SSN:_____-_____-_____ **Gender**: ☐ Male ☐ Female

Date of Birth:_____/____/_____ **Phone:** (____)_____

Address: _____

_____

Dependent Information

Name of Dependent: _____

SSN of Dependent:_____-_____-_____ **Gender**: ☐ Male ☐ Female

Date of Birth:_____/____/_____

Please enroll me into ☑ one:

☐ Medicare Indemnity Plan (BCBS)

☐ Medicare HMO Plan (BCBS)

☐ Aetna Medicare Advantage Plan*

☐ Enhanced Medicare Advantage Plan*

***Split plan option for dependent(s) under 65:**

☐ BCBS HMO

☐ BCBS Indemnity (PPO)

This request must be signed by the member, unless there is an appointed Durable Power of Attorney, which a copy must be attached.

Signature:_____ **Date:** _____

Medicare Eligibility

Retiree: Medicare Part A ☐ YES ☐ NO Medicare Part B ☐ YES ☐ NO

Effective Date:_____ Effective Date: _____

Medicare ID (HCN) #: _____

Dependent: Medicare Part A ☐ YES ☐ NO Medicare Part B ☐ YES ☐ NO

Effective Date:_____ Effective Date: _____

Medicare ID (HCN) #: _____

If you miss this deadline, you will have another opportunity to change coverage during the open enrollment period later in October.

Please return the completed form with a copy of your Medicare card to:

Fulton County Pension Office
ATTN: Retiree Benefits
141 Pryor Street, Suite 7001
Atlanta, GA 30303
(404) 612-7606

OR

(404) 612-1312 (E-FAX)
Email: pensionunit@fultoncountyga.gov