CHECK YOUR RETIREMENT PLAN

401A (New Plan) _____ (DB) Defined Benefit (Old Plan) _____

2020 Retiree Annual Enrollment Form

INFORMATION ABOUT YOU

Retiree Name (First Name, Last Name):		**Social Security #:**
Are you age 65 or older / Medicare Eligible: ☐ Yes ☐ No		
Retiree Home Address:		
Street:	*City:*	
	State:	*Zip:*
Home Phone:	**Cell Phone:**	**Email:**
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced	**Date of Hire:**____/____/____	**Date Retired:**____/____/____
Are *you* eligible for Medicare? ☐ Part A / Effective date:____/____/____	☐ Part B / Effective date:____/____/____	
Is *your spouse* eligible for Medicare? ☐ Part A / Effective date:____/____/____	☐ Part B / Effective date:____/____/____	
Is your or your spouse's Medicare coverage related to end-stage renal disease? ☐ Yes ☐ No		

YOUR HEALTH PLAN OPTIONS

Medical Plan Coverage Tier (Select One):

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren)
☐ Family ☐ Waive Coverage

Medical Plan Options—Retirees Under Age 65:
(Non-Medicare) SELECT ONE MEDICAL PLAN

☐ HSA Plan (Anthem BlueCross BlueShield)
☐ HMO Plan ((Anthem BlueCross BlueShield) - **NEW**
☐ POS Plan (BlueCross BlueShield of Georgia)
☐ HMO Plan (Kaiser Permanente)

Medical Plan Options—Retirees Age 65 or Older:
(Medicare) SELECT ONE MEDICAL PLAN

☐ Basic Medicare Advantage Plan (Aetna) *
☐ Enhanced Aetna Medicare Advantage Plan (Aetna)*
☐ Medicare Indemnity Plan (Anthem BlueCross BlueShield)
☐ Medicare HMO Plan (Anthem BlueCross BlueShield)
☐ PPO Plus Plan (Anthem BCBS —current participants only) Closed

*** To enroll in the Basic Aetna Medicare Advantage Plan or the Enhanced Aetna Medicare Advantage Plan for the first time, please contact Aetna directly: (800) 307-4830.**

Dental Plan (SELECT ONE DENTAL PLAN)

☐ Comprehensive Dental PPO Plan ☐ Dental HMO Plan - Primary Dentist Office ID_____(Required)

Dental Plan Coverage Tier (Select One):

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren)
☐ Family ☐ Waive Coverage

Vision Plan Coverage Tier (Select One):

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren)
☐ Family ☐ Waive Coverage

INDIVIDUALS TO BE COVERED*

Name (Last, First, M.I.)	Social Security #	Sex (M or F)	Birthdate (mm/dd/yyyy)	Disabled, before age 19?	Currently covered by Medicare?	Dependent Coverage Option (If Retiree is enrolled in Aetna Medicare Advantage Plan)
Self				☐ Yes	☐ Yes	
Spouse				☐ Yes	☐ Yes	**Anthem**
Child				☐ Yes	☐ Yes	☐ Medicare Indemnity Plan
Child				☐ Yes	☐ Yes	☐ Medicare HMO Plan
Child				☐ Yes	☐ Yes	

If any of your dependents listed above live at an address that is different than yours, please complete the following:

Name(s)	**Address(es)**

When enrolling dependents for the first time, you must submit with this enrollment form supporting documentation appropriate for the relationship of the dependent to you (e.g., marriage certificate, birth certificate, adoption placement papers, court-ordered child health coverage support affidavit, physician verification of permanent disability).

IF YOU ARE DECLINING COVERAGE

By completing this section, I acknowledge that I was given the opportunity to enroll for 2020 Fulton County health care coverage and am choosing not to enroll in one or more of the above benefit plans. I understand that if my dependents or I wish to enroll at a later date for any of the coverage(s) I have declined, I / they will be required to submit a new Enrollment Form and coverage may be subject to late enrollee provisions, as allowed by law and as directed by my employer.

Reason for refusal: (Please check all that apply)

☐ Other group coverage sponsored by my employer
☐ Other group coverage sponsored by my spouse's employer
☐ Other group coverage sponsored by another organization
☐ Other reasons (Please explain below)

FOR OTHER COVERAGE

Carrier:	Plan Number:
Telephone Number:	

Retiree Signature	**Date**

I hereby authorize a deduction to be made from my pay or drafted from my bank account on file (if applicable) as my share of the premium cost, as authorized by the Fulton County Board of Commissions. I certify the above information is true and correct and I am entitled to the coverage requested. I declare that all statements and information made hereon are complete and true to the best of my knowledge, I understand that any misstatements or omissions may void all coverage applied for any member on this application on a retroactive basis for up to two (2) years from the contract effective date.

Return completed form with any required supporting documentation to the
Fulton County Pension Office via:
fax: (404) 612-1312
email: pensionunit@fultoncountyga.gov

2020 Retiree Annual Enrollment Form

RIGHTS AND OBLIGATIONS

I hereby apply for myself and my eligible family members for the coverage specified in the Contract between my Group/Employer and BlueCross and BlueShield of Georgia, Aetna Medicare Advantage PPO, Kaiser Foundation Health Plan of Georgia HMO, Aetna Health Dental PPO or HMO, or EyeMed Vision (hereinafter referred to as the Plans).

I understand and agree that the effective date of coverage will be governed by the stipulations of the Group Application and the Master Group Contract under which this application is made. I understand that membership will continue according to the terms of the contract between the employer and the Plans. I hereby authorize the employer to periodically deduct any charge due from me hereunder and to remit same to the Plans along with any contribution due from the employer.

I hereby authorize any hospital, physician, psychiatrist, psychologist, counselor, psychiatric hospital or other provider, dispenser of prescription drugs, appliances, ambulance service or any person or any institution rendering services to me or members of my family, if covered hereunder, to furnish the Plans all requested information concerning treatment, advice, psychiatric care or medical care for previous or future conditions, illnesses or disabilities.

I declare that all statements made hereon including the information provided on the front of this application are complete and true to the best of my knowledge and belief, and agree that the Plans may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or false information has been submitted, personally assuming liability for reimbursement to the Plans for any benefit payment made on behalf of such family member. After this contract has been in force for a period of two (2) years during the lifetime of the insured, it shall become incontestable as to the statements in the applications. I understand that I am responsible for giving notice to my Group/Employer of any changes in my status and that of my family members that affect coverage.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. Your answers are required to determine if you qualify for coverage. Plans are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help obtain additional medical data from physicians or hospitals.

ALL DATA IS CONFIDENTIAL. Plans are required by law to keep such data confidential. It will be seen only by their employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. Plans may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of standard business practice or required by law.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information. You also have the right to send a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of information practices, please contact the applicable carrier:

- Anthem BlueCross and BlueShield of Georgia, Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908–7368
- Aetna, Inc., RT-52, 151 Farmington Avenue, Hartford, Connecticut 06156
- Kaiser Foundation Health Plan of Georgia, Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305
- EyeMed Vision Care, 4000 Luxottica Place, Mason, OH 45040.