FULTON COUNTY

2021 Retiree Open Enrollment Form

INFORMATION ABOUT YOU

Retiree name (first name, last name):		Social Security #:	
Street:	City:	State:	Zip:
Home phone:	Cell phone:	Email:	

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Type of Retirement Plan: ☐ Defined Benefit ☐ Defined Contribution

Are *you* eligible for Medicare? ☐ Yes ☐ No **Effective Dates:** Part A: ___/___/_____ Part B: ___/___/_____

Is *your spouse* eligible for Medicare? ☐ Yes ☐ No **Effective Dates:** Part A: ___/___/_____ Part B: ___/___/_____

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: SELECT ONE

- ☐ Anthem HSA Plan
- ☐ Anthem POS Plan
- ☐ Anthem HMO Plan
- ☐ Kaiser HMO Plan

Medical plan options—retirees age 65 or older: SELECT ONE

- ☐ Basic Aetna Medicare Advantage Plan*
- ☐ Enhanced Aetna Medicare Advantage Plan*
- ☐ Anthem Medicare Indemnity Plan
- ☐ Anthem Medicare HMO Plan
- ☐ Anthem PPO Plus Plan (current participants only)
- ☐ **New!** Kaiser Senior Advantage Plan

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

Dental plan coverage tier (select *one*): ☐ Retiree only ☐ Retiree + spouse ☐ Retiree + child(ren) ☐ Family ☐ Waive coverage

Dental plan: SELECT ONE ☐ Aetna Dental PPO Plan ☐ Aetna Dental HMO Plan—primary dentist ID_____(required)

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)	Permanently disabled before age 19?	Currently covered by Medicare?
Self				☐ Yes	☐ Yes
Spouse				☐ Yes	☐ Yes
Child				☐ Yes	☐ Yes
Child				☐ Yes	☐ Yes
Child				☐ Yes	☐ Yes

Dependent Coverage

65+ (Medicare-Eligible) Dependents

- ☐ Basic Aetna Medicare Advantage
- ☐ Enhanced Aetna Medicare Advantage
- ☐ Anthem Medicare Indemnity
- ☐ Anthem Medicare HMO

Pre-65 (Non-Medicare) Dependents

- ☐ Anthem HMO
- ☐ Anthem POS

***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

Please ensure you have checked the waived coverage box for all benefit plans you would like to waive. Electing to waive coverage means that you were given the opportunity to enroll for 2021 Fulton County health care coverage, but choose not to enroll in one or more of the above benefit plans.

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 Commissioners. I certify the above information is true and correct to the best of my knowledge and I am entitled to the coverage requested. 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 years from the contract effective date.

2021 Retiree Open 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 Anthem BlueCross and BlueShield of Georgia, Aetna Medicare Advantage PPO, Kaiser Foundation, Aetna Dental PPO or HMO, or EyeMed Vision PPO (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 I agree that the Plans may cancel this coverage, within two years from the effective date, for any ineligible family member for whom erroneous or false information has been submitted, and I personally assume 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 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:

- BlueCross and BlueShield of Georgia, Customer Service Department, P.O. Box 7368, Columbus, Georgia 31908
- 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