



Cobb County...Expect the Best!

Cobb County Government Retiree Benefit Election/Change Form

Name (Last, First, M.I.)		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Married <input type="checkbox"/> Single	Date of Birth:
Effective Date of Coverage/Change:		Type of Change: Add Coverage <input type="checkbox"/> Drop Coverage <input type="checkbox"/>		
QUALIFIED FAMILY STATUS CHANGE:		REQUIRED DOCUMENTATION:		
<input type="checkbox"/> Birth/Adoption/Guardian		Confirmation of birth or birth certificate/Legal Adoption/Guardianship paper		
<input type="checkbox"/> Death		Copy of Death Certificate		
<input type="checkbox"/> Change in Marital Status		Marriage: Copy of Marriage Certificate/license Divorce: copy of front & back of divorce decree		
<input type="checkbox"/> Change in spouse/dependent employment		Dated notice of hire or termination on employer letterhead*		
<input type="checkbox"/> Other:				
*When adding a spouse, submit marriage certificate and most recent tax return. When adding a dependent, please submit birth certificate				
I ELECT THE FOLLOWING BENEFIT:				
Medical Insurance	Blue Cross/Blue Shield	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Consumer Driven HRA	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Full Family	<input type="checkbox"/> WAIVE
	Kaiser Permanente	<input type="checkbox"/> HMO		
COVERED DEPENDENTS				
<input type="checkbox"/> Medical	Retiree:		Birth date	HMO PCP ID #
<input type="checkbox"/> Medical	Spouse: Last Name, First Name	Social Security #	Birth date	HMO PCP ID #
<input type="checkbox"/> Medical	Child 1: Last Name, First Name	Social Security #	Birth date College Student? Yes No	HMO PCP ID #
<input type="checkbox"/> Medical	Child 2: Last Name, First Name	Social Security #	Birth date College Student? Yes No	HMO PCP ID #
<input type="checkbox"/> Medical	Child 3: Last Name, First Name	Social Security #	Birth date College Student? Yes No	HMO PCP ID #
Federal law requires notice of COBRA rights to anyone losses coverage. Please provide current address if individual is losing coverage.				
ADDRESS:		CITY, STATE ZIP		

Spousal Questions

- My spouse is eligible for medical coverage through his/her current or former employer but has chosen to waive/decline that coverage and will be covered under the Cobb County's medical plan.
- \$100 monthly Spousal Surcharge will be added to existing medical premiums
- My spouse is employed, but is not offered health benefits through his/her employer.
- No Spousal Surcharge
- My spouse is eligible and has elected health benefits through his/her current or former employer.
Coverage under Cobb County is secondary insurance. Name of insurance company: _____
- No Spousal Surcharge
- My spouse is employed/retired with Cobb County.
- No Spousal Surcharge
- My spouse is unemployed; therefore, not eligible for an employer-sponsored health plan.
- No Spousal Surcharge

Tobacco Question

Do you use any type of tobacco products* or nicotine? YES NO
- \$54.16 monthly Tobacco Surcharge will apply to medical premiums

Fraud Certification- Carefully read the statement below before signing this form

I hereby authorize Cobb to reduce my pension payment by the amount of the premium for the plan I elected. I verify and certify that the information provided on this form is true and correct. I understand that should the circumstances change regarding my dependents and/or the availability of other health coverage during the plan year, **I am obligated to notify Human Resources within thirty (30) days of the change of circumstances and to immediately assume any monetary obligations** that arise because of the change of circumstances.

I understand that a deliberate misrepresentation or misstatement of the facts contained on this verification and certification **will result in the termination of medical coverage for a period of one year.** I further understand that **I will be responsible for the reimbursement of funds paid to providers** on my dependents' behalves **in the event that I have misrepresented or presented false** information.

Signature

Date

Cobb County Government

Affidavit Verifying Eligibility Status for Public Benefit(s)



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Pursuant to the *Georgia Security and Immigration Compliance Act* of 2006 (Senate Bill 529.GSICA), every agency administering or providing public benefits is responsible for determining U.S. citizenship or lawful alien status of applicants for said benefits. (O.C.G.A. § 50-36-1)

By executing this affidavit under oath, as an applicant for a retirement, disability, and/or health insurance benefits, the undersigned applicant verifies one of the following with respect to his/her application for a public benefit from Cobb County Government.

1. _____ I am a United States citizen.
2. _____ I am a legal permanent resident of the United States.
3. _____ I am a qualified alien or non-immigrant under the *Federal Immigration and Nationality Act* with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is: _____.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A ***United States passport or passport card***
- A ***driver's license issued by the United States***
- A ***tribal identification card***
- An ***Employment Authorization Document*** that contains a photograph of the bearer
- A ***passport issued by a foreign government***
- A ***Free and Secure Trade (FAST) card***
- A ***United States military identification card***
- An ***identification card issued by the United States***
- ***US Permanent Resident Card or Alien Registration Receipt Card***
- A ***Merchant Mariner Document or Credential***

The secure and verifiable document provided with this affidavit can best be classified as:

(list document and provide a copy) _____

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20 and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____ (state)

Signature of Applicant

Printed Name of Applicant

Subscribed and sworn before me on this the

_____ day of _____, 20_____

Notary public: _____

My commission expires: