



Cobb County Government Retiree Benefit Election/Change

Retiree Name (Last, First, M.I.)	Female Male	Married Single	New Retiree Current Retiree	Date of Birth
Effective Date of Coverage/Change:	Type of Change: Add Coverage Drop Coverage			
QUALIFIED FAMILY STATUS CHANGE:		REQUIRED DOCUMENTATION:		
Birth/Adoption/Guardian		Confirmation of birth or birth certificate/Legal Adoption/Guardianship paper		
Death		Copy of Death Certificate		
Change in Marital Status		Marriage: Copy of Marriage Certificate/license Divorce: copy of front & back of divorce decree		
Change in spouse/dependent employment		Above documents and dated notice of hire or termination on employer letterhead		
Other:				
I ELECT THE FOLLOWING BENEFITS on a "pre-tax" basis:				
Medical Insurance	Blue Cross/Blue Shield HMO (Open Access POS POS Network) HRA Kaiser Permanente HMO		Single WAIVE Single + Spouse Single + Child(ren) Full Family	
COVERED DEPENDENTS (Add or Drop individual only)				
Medical	Retiree:		Birth date	Add Coverage Drop Coverage
Medical	Spouse: Last Name, First Name Male Female	Social Security #	Birth date	Add Coverage Drop Coverage Disabled
Medical	Child 1: Last Name, First Name Male Female	Social Security #	Birth date Live out of state? Yes No	Add Coverage Drop Coverage Disabled
Medical	Child 2: Last Name, First Name Male Female	Social Security #	Birth date Live out of state? Yes No	Add Coverage Drop Coverage Disabled
Medical	Child 3: Last Name, First Name Male Female	Social Security #	Birth date Live out of state? Yes No	Add Coverage Drop Coverage Disabled
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 (If adding spouse to coverage, submit your marriage certificate)

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 biweekly 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 also employed by Cobb County and covered under Cobb County's medical plan.

- **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

- **\$75.83 biweekly 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)



Cobb County...Expect the Best!

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 (Retiree) for a retirement, disability, and/or health insurance benefits, the undersigned applicant (Retiree) 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 (Retiree)

Printed Name of Applicant (Retiree)

Subscribed and sworn before me on this the

_____ day of _____, 20_____

Notary public: _____

My commission expires: