Cobb County...Expect the Best!

Cobb County Government
Benefit Election/Change Form

Employee Name (Last, First, M.I.)	☐ Female ☐ Male	☐ Married ☐ Single	☐ New Employee ☐ Current Employee	Employee ID #
Date of Hire:	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 .

☐ 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*** (Open Access POS Network)	☐ HMO ☐ POS ☐ HRA	☐ Single ☐ Single + Spouse ☐ Single + Child(ren) ☐ Full Family	☐ WAIVE
	Kaiser Permanente	☐ HMO		
Dental Insurance	**Delta Dental** (PPO and Premier Network)		☐ Single ☐ Full Family	☐ WAIVE

COVERED DEPENDENTS (Add or Drop individual only)

☐ Medical ☐ Dental	**Spouse:** Last Name, First Name ☐ **Male** ☐ **Female**	Social Security #	Birth date	Coverage: Add ☐ Drop ☐ Disabled? ☐
☐ Medical ☐ Dental	**Child 1:** Last Name, First Name ☐ **Male** ☐ **Female**	Social Security #	Birth date Live out of state? Yes No	Coverage: Add ☐ Drop ☐ Disabled? ☐ FT Student? ☐
☐ Medical ☐ Dental	**Child 2:** Last Name, First Name ☐ **Male** ☐ **Female**	Social Security #	Birth date Live out of state? Yes No	Coverage: Add ☐ Drop ☐ Disabled? ☐ FT Student? ☐
☐ Medical ☐ Dental	**Child 3:** Last Name, First Name ☐ **Male** ☐ **Female**	Social Security #	Birth date Live out of state? Yes No	Coverage: Add ☐ Drop ☐ Disabled? ☐ FT Student? ☐

I ELECT THE FOLLOWING BENEFITS on a "after-tax" basis:

Group Dependent Life Insurance (If elected, all eligible dependents listed above are covered; child must be FT student if 19 or older. Student not eligible after age 25) **School enrollment verification letter required if FT student**	☐ Enroll ☐ Decline

Federal law requires notice of COBRA rights to anyone losing 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. ***– $46.15 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. ***– No Spousal Surcharge***
Coverage under Cobb County is secondary insurance. Name of insurance company: _____

☐ 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 (Must be tobacco/nicotine free in the past 6 months)

**Tobacco products are defined as cigarettes, snuff, chewing tobacco, cigars, pipe tobacco or any nicotine absorbed products such as the patch or nicotine gum or electronic nicotine delivery systems such as vapes or e-cigarettes or any other similar product.*

– $35 biweekly Tobacco Surcharge will apply to medical premiums

Clinic Policy Change/No Show Acknowledgement **Carefully read the statement below before signing this form**

☐ When using the CobbHealth Wellness Clinic, I acknowledge and agree that a $25 fee will be deducted from my paycheck if I do not give at least a 24-hour notice to the Health Clinic staff in the event I or my covered dependents need to cancel or reschedule an existing appointment. I agree that the fee will be deducted from my paycheck within 30 days of the "no show" appointment. I further acknowledge the fee may be waived in the event the appointment was missed due to work obligations or extenuating circumstances. I will provide information regarding any extenuating circumstance or written verification from my management regarding work obligations to the Clinic staff within five (5) business days for the fee to be waived. The Clinic staff will make the final decision to waive the fee.

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

I hereby authorize Cobb County to make the changes listed above and adjust my salary accordingly. I verify and certify that the information provided on this form is true and correct. I understand that should 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 form **will result in termination of medical coverage for a period of one year.** I further acknowledge and understand that **providing false information is fraud**, and if the above answers are misrepresented or contain false information, **I may be subject to disciplinary action up to and including possible termination of employment.**

_____ Employee 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: