FULTON COUNTY

Employee Benefits Division
141 Pryor Street SW, Suite 7001
Atlanta, GA 30303
Phone: 404-612-7605
Email: employeebenefits@fultoncountyga.gov
Fax: 404-612-3675

# New Hire Active Employee Enrollment Form

| INFORMATION ABOUT YOU | | | |
|---|---|---|---|
| Name (first name, last name): | | | |
| Address: | City: | State: | Zip Code: |
| Birthdate: | Social Security #: | Department name: | |
| Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced | | | |

| YOUR HEALTH PLAN OPTIONS | | | | |
|---|---|---|---|---|
| Medical plan coverage tier (select one): | ☐ Employee only | ☐ Employee + 1 | ☐ Family | ☐ Waive coverage |
| Medical plan options: SELECT ONE MEDICAL | ☐ Anthem HSA Plan | ☐ Kaiser HMO Plan | | |
| Dental plan coverage tier (select one): | ☐ Employee only | ☐ Employee + 1 | ☐ Family | ☐ Waive coverage |
| Dental plan options: SELECT ONE DENTAL PLAN | ☐ Aetna Dental PPO Plan | ☐ Aetna Dental HMO Plan | | |
| EyeMed Vision PPO Plan coverage tier (select one): ☐ Employee only | ☐ Employee + 1 | ☐ 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? |
| Self | | | | ☐ Yes |
| Spouse | | | | ☐ Yes |
| Child | | | | ☐ Yes |
| Child | | | | ☐ Yes |
| Child | | | | ☐ Yes |

| METLIFE SUPPLEMENTAL AND DEPENDENT LIFE INSURANCE | DEPENDENT LIFE |
|---|---|
| ☑ $50,000 (mandatory enrollment) | ☐ $10,000 per dependent |

**SUPPLEMENTAL LIFE INSURANCE (UP TO $300,000)**

| | | | | | |
|---|---|---|---|---|---|
| ☐ $25,000 | ☐ $75,000 | ☐ $125,000 | ☐ $175,000 | ☐ $225,000 | ☐ $275,000 |
| ☐ $50,000 | ☐ $100,000 | ☐ $150,000 | ☐ $200,000 | ☐ $250,000 | ☐ $300,000 |

**BENEFICIARY DESIGNATION:** If you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiaries. If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

| Name (last, first, M.I.) | Social Security # | Relationship | Benefit Percentage (%) |
|---|---|---|---|
| Primary | | | |
| Primary | | | |
| Contingent | | | |
| Contingent | | | |

**IF YOU ARE DECLINING MEDICAL COVERAGE**

I understand that I have been given an opportunity to apply for medical, dental and/or vision benefits as offered by my employer. After careful consideration, I have decided not to take advantage of this offer because I have equitable coverage for myself, or as a covered dependent of my spouse, through another plan. I agree to notify the County if my coverage is discontinued, so that my coverage through the County may begin the date that my current coverage ends.

Reason for refusal (check all that apply):

☐ Spouse of County employee:
Spouse name:_____
Last 4 SSN #: _____

☐ Other group coverage sponsored by spouse's employer

☐ Other group coverage sponsored by another organization

☐ Other: _____

For other coverage: Attach proof of other coverage and complete the below plan information.

Carrier: | Plan number:

Telephone number:

**Employee ID #:**_____ **Date:**_____

**Employee Signature:**_____

**Send your completed form to the Fulton County Employee Benefits Division:**
**employeebenefits@fultoncountyga.gov or 404-612-3675 (fax)**

FULTON COUNTY

Employee Benefits Division
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Fax: 404-612-1870

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 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 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 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, Post Office 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