

Retiree Health Benefits Change Form

COBB COUNTY GOVERNMENT



Cobb County...Expect the Best!

Section 1 - Employee Information

Retiree Name: _____ Social Security #: _____

NOTE: Dependents may only be added or dropped within 30 days eligibility period of a qualified family status change. Any other changes to eligibility can be made during the annual enrollment period. Check appropriate box below and submit with required documentation.

QUALIFIED FAMILY STATUS CHANGE:

REQUIRED DOCUMENTATION:

- | | |
|---|---|
| <input type="checkbox"/> Birth, Adoption, or Legal Guardianship of Child. | Birth: Confirmation of birth or birth certificate. Adoption: Legal adoption papers. Guardianship: Legal guardianship papers. |
| <input type="checkbox"/> Dependent not qualified / is qualified | Not qualified (over 19, not FT student): This form only. Qualified (over 19, is FT student): School registration. |
| <input type="checkbox"/> Change in Marital Status | Marriage: copy of marriage certificate. Divorce: copy of front and back page of divorce decree. |
| <input type="checkbox"/> Death of spouse or dependent | Copy of death certificate. |
| <input type="checkbox"/> Retirement - Retiree elects a new plan | N/A |
| <input type="checkbox"/> Change in employment/benefits (you or your spouse) | Notice of change from spouse's employer on employer letterhead. |
| <input type="checkbox"/> Significant change in spouse's health coverage | Notice of change from spouse's employer on employer letterhead. |

Effective Date of Change: _____

Section 2 - Medical Plan - complete only if coverage was previously waived.

Medical Plan: HMO * PPO CDHP Kaiser HMO * Waive

Effective Date of Change: _____ Tobacco User? Yes No

* HMO Plans must select a Primary Care Physician (PCP) for each enrolled member. If you selected an HMO plan above, please complete the following:

PCP Name: _____ PCP ID #: _____ Existing Patient: Yes No

MEDICARE ADVANTAGE: Retiree (and spouse, if applicable) must both be enrolled in Medicare Part A & B and attach a copy of their Medicare ccards.

Section 3 - COBRA

Federal Law requires that extension of coverage (COBRA) be offered when an employee or dependent loses coverage. Please provide current address for the dependent(s) above losing coverage.

Name: _____ Address: _____

Section 4 - Authorization

I hereby apply for the changes, adjustments or additions to my existing information indicated above. This application shall supersede any previous application as of its signed date. I understand if I choose to drop coverage and wish to add coverage at a later date, I must wait until the annual enrollment period.

Retiree Signature/Date: _____

Human Resources Use Only

New Health Code

New Dental Code

Dep Life

Section 5 - Revised Dependent Information (if electing single coverage, skip this section)

I elect to: ADD DROP the spouse and/or dependents listed below to the change indicated.

Spouse (Marriage Certificate Required):

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: M F Social Security #: _____ Birthdate: _____

Electing the following coverage (check all that apply): Medical

HMO Plan Only: PCP Name: _____ PCP ID #: _____ Existing Patient: Yes No

Dependent children who are not full-time students can be covered under **MEDICAL COVERAGE ONLY**. If you elect to cover a dependent over the age of 19 up to the age of 26, you must provide proof that the child is enrolled full-time in a post-secondary institution of higher learning at least five (5) months in a calendar year (school registration or enrollment form).

Child 1 (Birth Certificate Required):

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: M F Social Security #: _____ Birthdate: _____

Electing the following coverage (check all that apply): Medical

HMO Plan Only: PCP Name: _____ PCP ID #: _____ Existing Patient: Yes No

College Student? Yes No *Attach proof from college*

Child 2 (Birth Certificate Required):

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: M F Social Security #: _____ Birthdate: _____

Electing the following coverage (check all that apply): Medical

HMO Plan Only: PCP Name: _____ PCP ID #: _____ Existing Patient: Yes No

College Student? Yes No *Attach proof from college*

Child 3 (Birth Certificate Required):

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: M F Social Security #: _____ Birthdate: _____

Electing the following coverage (check all that apply): Medical

HMO Plan Only: PCP Name: _____ PCP ID #: _____ Existing Patient: Yes No

College Student? Yes No *Attach proof from college*

If you have additional dependents, please attach a separate sheet.

Mail completed form to Cobb County Human Resources, Benefits Division, 100 Cherokee St. Marietta, GA 30090