CITY OF ATLANTA
68 Mitchell St., SW
City Hall – Suite 2120
Atlanta, GA 30303

INSURANCE ENROLLMENT APPLICATION

RETIREE

RETIREE LAST NAME	FIRST NAME		MIDDLE INITIAL
STREET ADDRESS			
CITY	STATE	ZIP CODE	COUNTY
HOME PHONE	BUSINESS PHONE	SOCIAL SECURITY NUMBER	
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED		DATE OF MARRIAGE	
DATE OF RETIREMENT:	PENSION FUND:	BENEFICIARIES: ☐ SPOUSE ☐ CHILD	

ELIGIBILITY APPROVED BY	
DATE	
DATE OF RETIREMENT	TERMINATION DATE
EFFECTIVE DATE	
PROCESSED BY	
DATE	

Instructions for Enrollment: New retirees use date of retirement for effective date _____. If you do not enroll within 31 days of retirement, you may enroll only during the next Open Enrollment, to be effective the following plan year.

****PLEASE READ**** Eligible dependents are: **Your spouse/Domestic Partner and children up to age 26**. Children for whom you have assumed legal obligation may be covered provided they are dependent on you for support. **You must attach a copy of guardianship or adoption papers.** For dependent spouse/Domestic Partner, attach marriage certificate or domestic partnership agreement. For each dependent child, attach birth certificate showing parent-child relationship. **If you do not enroll your dependent(s) within 31 days of the date the dependent(s) is eligible to enroll (i.e., date of birth, marriage, etc.), you may enroll the dependent(s) only during the next Open Enrollment period to be effective the following plan year.**

I DO NOT WANT CITY HEALTH AND/OR DENTAL/VISION COVERAGE.

I hereby certify that I have been given an opportunity to participate in the City of Atlanta Health, Dental, and Vision Insurance Plans for myself and my eligible dependents. All plans have been thoroughly explained to me and I decline to participate in:

☐ HEALTH ☐ DENTAL ☐ VISION	RETIREE SIGNATURE	DATE

I ELECT: (INITIAL YOUR CHOICE OF PLANS)

Medical	Dental
☐ Anthem BCBS Gatekeeper POS	☐ Anthem BCBS PPO High
☐ Kaiser Permanente HMO	☐ Anthem BCBS PPO Low
☐ UHC Medicare Advantage PPO (Parts A & B)	☐ Aetna DHMO (GA only)
☐ Anthem BCBS Medicare Advantage PPO (Parts A & B)	**Vision**
☐ Kaiser Permanente Senior Advantage HMO (Parts A & B)	☐ UnitedHealthcare Vision
☐ UHC Medicare Advantage (Part B Only)	
☐ Anthem BCBS Medicare Advantage PPO Split Option Plan (Parts A & B)	
☐ Kaiser Permanente HMO + Senior Advantage (Medicare) Split Option Plan	

Enter below family members to be covered: YOURSELF, SPOUSE/DOMESTIC PARTNER, THEN CHILDREN

Last Name, First Name, MI	Sex	Social Security Number	Rel.	Date of Birth	MED	DEN	VIS
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

I hereby apply for enrollment for myself and the eligible dependents listed above and swear and affirm that the above information is true and correct to the best of my knowledge and belief. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I agree to pay the premium amounts applicable to the contract under which I am covered. I understand that I cannot change or stop deductions on any date other than at Open Enrollment except for a qualifying change in my family status. I authorize the Chief Financial Officer of the City of Atlanta to deduct from my pay such applicable premium amounts and to remit them to the insurance company/HMO I have chosen.

I authorize my provider, insurance company/HMO, or person with any record of knowledge of my health to furnish the above insurance company/HMO with such information. Concurrent with my hospitalization, I authorize the above insurance company/HMO to release or obtain medical information from healthcare providers to administer the plan.

I acknowledge that I and my spouse/Domestic Partner have read the Notification of Continuation of Coverage shown on the back of this form.

RETIREE SIGNATURE	DATE	SPOUSE/DOMESTIC PARTNER SIGNATURE	DATE

You and your spouse/Domestic Partner must sign this form, make a copy for yourself, and return the original form to DHR – Employee Benefits. If you need help in completing this form, call DHR – Employee Benefits at 404-330-6036.

CONTINUATION OF COVERAGE NOTICE

Under COBRA, the Consolidated Omnibus Reconciliation Act of 1985 Title X, terminated employees and their eligible dependents may continue group health plan coverage. We urge you to read this description of the “continuation coverage” option carefully, and to make sure you and your spouse/domestic partner read and understand the rights and responsibilities in connection with this continuation of coverage. Both you and your spouse/domestic partner must sign the front page of this enrollment application.

THE BENEFITS

Effective January 1, 1987, if you are currently under the City of Atlanta Health Plan, including HMOs, you will be entitled to continue your and your family’s Health Plan coverage for up to 18 months from the date coverage would have terminated because of voluntary or involuntary termination. If a qualified beneficiary is deemed disabled for Social Security, at the date of the qualifying event or within the first 60 days following the qualifying event, the continuation coverage period is 29 months for all the members of your family who have elected COBRA. The 18-month period may be extended also if other events (such as a death or divorce) occur during that 18-month period. Employees discharged because of “gross misconduct” would not be eligible for continuation of coverage. Dependents who no longer qualify as dependents under the City of Atlanta Health Plan are eligible to apply for continuation of coverage. If you should die or become divorced, and if your spouse/domestic partner and dependents are covered by the City of Atlanta Health Plan at that time, they will be entitled to continue health coverage for up to 36 months. Continuation coverage also is available for your children for up to 36 months or up to age 26 if they are not covered under another group health plan that duplicates coverage. If an Eligible Person is 60 years old on the date COBRA continuation coverage starts, COBRA coverage may extend up to the time of Medicare eligibility. If you have a newborn child, adopt a child, or have a child placed in your home pending adoption (for whom you have financial responsibility), while your COBRA continuation coverage is in effect, you may add this child to your coverage.

THE COST

Continuation of coverage is optional on the part of the employee or dependent. Those who elect continuation of coverage will be required to pay 102% of the total monthly group premium for the applicable class of coverage. For the extended disability coverage, employees may be required to pay up to 150% of the monthly group premium during the 19th through the 29th month. Persons 60 years old on the date of COBRA eligibility may be required to pay up to 120% of the premium for extended time. There will be no contribution made by the City of Atlanta. Premiums are due monthly and in advance. You should note that your continuation coverage will stop if the premiums for this coverage are not paid on time.

If you elect to continue coverage, new dependents may be added during the period of continuation on the same basis as they are added for active employees. If during continuation of coverage health benefits and premium rates change, your coverage and costs will be affected accordingly. Should Open Enrollment occur during the period of your continuation, you will retain your right to switch to a different option.

WHEN COVERAGE ENDS

If you or covered members of your family become entitled to Medicare or are covered under another employer-sponsored health plan that does not limit coverage due to preexisting conditions, the continuation coverage from the City of Atlanta Health Plan will cease. In addition, your coverage will cease if the City of Atlanta should terminate the Health Plan or you cease to pay premiums. Once the period of coverage continuation has expired, anyone receiving continuation coverage will be eligible to convert to individual policies, as provided under the City of Atlanta Plan.

WHAT YOU MUST DO

You or your spouse/domestic partner or dependents must notify the Employee Benefits Division when your dependent child reaches the maximum age under the plan or in the event you become divorced. It is important that you notify us of your or your dependent’s loss of Plan eligibility promptly — in advance, if possible, but no later than 60 days from the date coverage would otherwise have been terminated, in order to be eligible to elect continuation coverage. Within 14 days after the end of the month in which you notify the Employee Benefits Division, you or your eligible dependents will be mailed information and forms regarding continuation of coverage. You or your dependents will then have an additional 45 days to pay the applicable premium, retroactive to the date coverage would otherwise have terminated.

If you would like further information about continuation coverage under the City of Atlanta Health Plan, please contact DHR – Employee Benefits at 404-330-6036.

CONVERSION PRIVILEGE

When your group health insurance ends due to your termination of employment with the City of Atlanta or due to expiration of COBRA continuation of health care coverage under the group contract, you may apply for converted health coverage. For additional information contact DHR – Employee Benefits at 404-330-6036.

If you are a new employee, have previously waived your health insurance, or are adding a dependent other than a newborn (or child placed in your home pending adoption), you should provide copies of the CERTIFICATE OF GROUP HEALTH PLAN COVERAGE issued to you or your dependents by the previous employer(s) for CREDITABLE PRIOR COVERAGE so that you can avoid preexisting condition exclusions, if any.