# Health Benefits Enrollment Form

*Georgia Municipal Employees Benefit System (GMEBS) Life & Health*

| City / Authority Name: | Employee Hire Date: |
|---|---|

## **Section 1:** Eligible Employee Demographics

| | | | |
|---|---|---|---|
| SSN * | Date of Birth * | Sex * ◯ Male ◯ Female | |
| Last Name * | First Name * | MI | Suffix |
| Home Address * | | Apt/Unit | |
| City * | State * | Zip Code * | |
| Phone * | Email Address * | | |
| Marital Status * ◯ Single ◯ Married ◯ Divorced ◯ Widowed | | | |

## **Section 2:** Eligible Employee Coverage Elections

*Please select desired Health plans and coverage below or check this box to waive all.*

☐ ***Waive All GMA-Administered Health Coverage(s) (i.e., Medical, Dental, and Vision)***

| Medical ◯ Yes ◯ No | Dental ◯ Yes ◯ No | Vision ◯ Yes ◯ No |
|---|---|---|
| Health Plan / Deductible | | |
| ◯ POS _____ | | |
| ◯ PPO _____ | | |
| ◯ HMO _____ | | |
| ◯ HDHP-HSA _____ | | |

| **NEXT STEPS:** | | |
|---|---|---|
| If enrolling yourself + dependents: | If enrolling only yourself: | If waiving all coverage options: |
| • Complete Sections 3, 4, & 5<br>• SSNs are required | • Select "No" in Sections 3 & 4 and continue to Section 5 | • Continue to Section 5 |

**SUPPORTING DOCUMENTS REQUIRED:**

Required documents must be attached in order for this enrollment to be processed.

See Section 5 for a list of documents to be attached.

| SSN | Last Name | First Name |
|---|---|---|

## **Section 3:** Spouse Coverage Elections

**Are you enrolling a Spouse?** ◯ Yes ◯ No

*If yes, you must attach a **MARRIAGE CERTIFICATE**.*

*You must immediately notify GMA of divorce from this Spouse.*

**Which coverage(s) are you electing for your Spouse?** ☐ Medical ☐ Dental ☐ Vision

| SSN | Date of Birth | Sex ◯ Male ◯ Female | |
|---|---|---|---|
| Last Name | First Name | MI | Suffix |

## **Section 4:** Eligible Child(ren) Coverage Elections

**Are you enrolling a Child?** ◯ Yes ◯ No

*If yes, you must attach **PROOF OF ELIGIBLE CHILD STATUS**. (See Section 5 for details) Child(ren) must be under age 26 unless disabled before age 26. You must immediately notify GMA if child(ren) loses eligibility.*

**Which coverage(s) are you electing for Child 1?** ☐ Medical ☐ Dental ☐ Vision

| SSN | Date of Birth | Sex ◯ Male ◯ Female | |
|---|---|---|---|
| Last Name | First Name | MI | Suffix |

Relation to Employee ◯ Biological Child ◯ Adopted Child ◯ Stepchild ◯ Employee is current Legal Guardian | Disabled? ◯ Yes ◯ No

**Are you enrolling a 2nd Child?** ◯ Yes ◯ No

**Which coverage(s) are you electing for Child 2?** ☐ Medical ☐ Dental ☐ Vision

| SSN | Date of Birth | Sex ◯ Male ◯ Female | |
|---|---|---|---|
| Last Name | First Name | MI | Suffix |

Relation to Employee ◯ Biological Child ◯ Adopted Child ◯ Stepchild ◯ Employee is current Legal Guardian | Disabled? ◯ Yes ◯ No

**Are you enrolling a 3rd Child?** ◯ Yes ◯ No

**Which coverage(s) are you electing for Child 3?** ☐ Medical ☐ Dental ☐ Vision

| SSN | Date of Birth | Sex ◯ Male ◯ Female | |
|---|---|---|---|
| Last Name | First Name | MI | Suffix |

Relation to Employee ◯ Biological Child ◯ Adopted Child ◯ Stepchild ◯ Employee is current Legal Guardian | Disabled? ◯ Yes ◯ No

| SSN | Last Name | First Name |
|---|---|---|

| **Are you enrolling a 4th Child?** ◯ Yes ◯ No | | | |
|---|---|---|---|
| **Which Coverage(s) are you electing for Child 4?** ☐ Medical ☐ Dental ☐ Vision | | | |
| SSN | Date of Birth | Sex ◯ Male ◯ Female | |
| Last Name | First Name | MI | Suffix |
| Relation to Employee ◯ Biological Child ◯ Adopted Child ◯ Stepchild ◯ Employee is current Legal Guardian | | Disabled? ◯ Yes ◯ No | |

## **Section 5:** Employee Affirmation

**Summaries of Benefits and Coverage**

You may obtain a Summary of Benefits and Coverage (SBC), which summarizes important information about the medical plan(s) offered by your employer. The SBC(s) will help you understand the medical plan(s) and compare your options (if more than one plan option is offered by your employer). Note: except for emergency services, benefits in an HMO option are provided only when covered services are provided by an HMO participating provider. The SBCs are available on the web at www.gacities.com/lhforms. A free paper copy is also available by calling 1-888-488-4462.

**SAVE Affidavit**

**This application for enrollment in the health plan will not be complete until the employee requesting benefits submits to GMA a properly completed SAVE AFFIDAVIT of his or her lawful presence in the United States and a copy of a secure and verifiable identification document.** GMA will verify any alien registration number provided through the Federal Systematic Alien Verification of Entitlement (SAVE) program, or a successor program designated by the United States Department of Homeland Security. Until this verification is made, a properly completed affidavit may be presumed to be proof of such employee's lawful presence for the purpose of receiving health benefits. If SAVE is unable to verify an an enrolled employee's lawful presence in the United States, the employee's health benefits will be terminated retroactively.

**REQUIRED DOCUMENTATION (TO PROVE ELIGIBILITY) MUST BE ATTACHED. Additional documentation may be required.**

- **SAVE Affidavit**
- **Secure and Verifiable identification** (see 'list provided by the Attorney General' on the affidavit for details)
- A copy of the **Marriage Certificate** if enrolling a Spouse or Stepchild. You must notify GMA immediately of divorce.
- A copy of the **Birth Certificate** if enrolling any Child.
- Also required (if applicable): **Court Order** showing placement for adoption or current legal guardianship
  Completed **Disability Form** if child is age 26 or older

*You must notify GMA immediately of end of legal guardianship or child disability status.*

**Employee Affirmation:** *

☐ I affirm that the information provided in this form and the attached documents are correct and accurate. I will notify GMA immediately of the end of a marriage, guardianship, or disability that is the basis of a dependent's eligibility. I understand failure to do so may be considered fraud and dependent eligibility may be audited.

| Employee Signature * _____ | Date * _____ |
|---|---|

| SSN | Last Name | First Name |
|---|---|---|

## **Section 6:** Employer Affirmation *(To Be Completed By Employer Only)*

| Employee Date of Hire * | Coverage Effective Date * |
|---|---|
| Date of Transfer Into Eligible Position * | Employee Job Title * |

Employee Benefit Class* ◯ Regular ◯ Department Head ◯ Elected Official

☐ **Waive Employee Waiting Period**
**You must submit a Memo, on letterhead, to the Life and Health Department for approval. Waivers are approved on an "As Needed" basis.*

**Employer Affirmation: ***

☐ I affirm that the individual listed above meets the requirements for eligibility associated with the marked Employee Benefit Class as set forth in the Employer's applicable Declaration Pages.

| Employer Signature * _____ | Date * _____ |
|---|---|