Instructions

for Completing the Health Benefits Change Form

DEADLINE: To add coverage due to a life event, you must submit this form no later than 31 days after the event date (60 days if event is Premium Assistance Subsidy or loss of Medicaid or CHIP). After the deadline has passed, the request to add coverage must wait until the next Open Enrollment period.

Section 1

If changing existing coverage for the Employee (and/or adding or dropping dependent coverage for an enrolled Employee):

- Please complete only the required fields in Section 1 before proceeding to Section 2. *If the Employee is already enrolled, do NOT complete the address, phone, email, and marital status fields in Section 1.*

If the Employee is a first-time enrollee for health benefits:

- Please complete all fields in Section 1 before proceeding to Section 2.
- A Health Plan and Deductible must also be specified in Section 5.
- ***If the Employee is a first-time enrollee, the SAVE Affidavit and Secure and Verifiable Identification must be attached.*** *See section 6 of the form.*

Section 2

Important: ***Life Event change requests cannot be submitted on the same form as Open Enrollment change requests – they must be submitted on separate forms.***

Life Event Changes – Complete this portion only if the reason for the change is a life event and not due to Open Enrollment.

Demographic Changes – Complete this portion only if there are changes or corrections to information previously provided to GMA.

- Check either "employee" or "dependent." ***If a dependent, enter the name of the dependent.***
- Check the type of information that has changed/should be corrected and fill in the previous and new information***. Leave all other lines blank.***

Open Enrollment Changes – Complete this portion only if making a change during the Open Enrollment period. (Life Event portion must be blank.)

Sections 3 and 4

Each time you select "Yes," fill in the demographic information about the dependent whose coverage will be changed. If you select "No," proceed to the next Section.

Section 5

If the Employee is enrolling in medical coverage for the first time, the desired medical plan must be marked and the desired deductible must be selected from the drop-down. Please ensure to select a plan that is offered by your employer. For currently enrolled Employees, leaving this section blank means the previously elected medical coverage will continue.

Sections 6 and 7

Read these sections carefully to determine which required documents must be attached. Attach the required documents to the form upon submission. Sign and date where indicated.

Health Benefits Change Form

Georgia Municipal Employees Benefit System (GMEBS) Life & Health

City / Authority Name*

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: Reason for Change

Life Event Changes

Add Coverage: Date of Event _____

☐ Marriage ☐ Loss of Previous Coverage ☐ Court Order/NMSN

☐ Birth ☐ Adoption ☐ Eligible for State Premium Assistance Subsidy

Drop Coverage: Date of Event _____

☐ Divorce ☐ Employee Loss of Eligibility ☐ Dependent Loss of Eligibility (Divorce, End of Legal Guardianship, End of Disability Status)

☐ Eligible for Medicare ☐ Coverage No Longer Needed

☐ Death of Dependent ☐ Other _____

Demographic Changes ◯ Employee ◯ Dependent - Name: _____

	Previous	New
☐ Name		
☐ Social Security Number		
☐ DOB		
☐ Marital Status		
☐ Address — Street		
City, State, Zip		

Open Enrollment

☐ Dropping coverage effective December 31

☐ Adding coverage effective January 1

☐ Changing from one Medical plan to another, effective January 1

SSN	Last Name	First Name

Section 3: Spouse Demographics

Are you adding or dropping Spouse coverage?* ◯ Yes ◯ No

*If adding spouse coverage, you must attach a **MARRIAGE CERTIFICATE**. (See Section 6 for details)*

Last Name	First Name	MI	Suffix
SSN	**DOB**	**Sex**	
		◯ Male	◯ Female

Section 4: Eligible Child(ren) Demographics

Are you adding or dropping coverage for a child?* ◯ Yes ◯ No

*If adding coverage for eligible child(ren), you must attach **PROOF OF ELIGIBLE CHILD STATUS**. (See Section 6 for details)*

Last Name	First Name	MI	Suffix
SSN	**DOB**	**Sex**	
		◯ Male	◯ Female
Relation to Employee		**Disabled?**	
◯ Biological Child ◯ Adopted Child ◯ Stepchild ◯ Employee is Current Legal Guardian		◯ Yes	◯ No

Are you adding or dropping coverage for a 2nd child? ◯ Yes ◯ No

Last Name	First Name	MI	Suffix
SSN	**DOB**	**Sex**	
		◯ Male	◯ Female
Relation to Employee		**Disabled?**	
◯ Biological Child ◯ Adopted Child ◯ Stepchild ◯ Employee is Current Legal Guardian		◯ Yes	◯ No

Are you adding or dropping coverage for a 3rd child? ◯ Yes ◯ No

Last Name	First Name	MI	Suffix
SSN	**DOB**	**Sex**	
		◯ Male	◯ Female
Relation to Employee		**Disabled?**	
◯ Biological Child ◯ Adopted Child ◯ Stepchild ◯ Employee is Current Legal Guardian		◯ Yes	◯ No

Are you adding or dropping coverage for a 4th child? ◯ Yes ◯ No

Last Name	First Name	MI	Suffix
SSN	**DOB**	**Sex**	
		◯ Male	◯ Female
Relation to Employee		**Disabled?**	
◯ Biological Child ◯ Adopted Child ◯ Stepchild ◯ Employee is Current Legal Guardian		◯ Yes	◯ No

SSN	Last Name	First Name

Section 5: Health Coverage Elections

If enrolling in Medical coverage for the first time or transferring to a new Medical plan, please select your desired plan and fill in the deductible amount:

Health Plan	Deductible	Health Plan	Deductible
◯ POS		◯ HMO	
◯ PPO		◯ HDHP-HSA	

	Medical	Dental	Vision
Employee:*	◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
Spouse:	◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
Child 1:	◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
Child 2:	◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
Child 3:	◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
Child 4:	◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop

Section 6: Notices & Required Documents

NOTICES:

- You may obtain a **Summary of Benefits and Coverage** (SBC), which summarizes important information and helps you understand the medical plan(s) offered by your employer and compare your options. The SBCs are available at www.gacities.com/lhforms. Call 1-888-488-4462 for a free paper copy.
- Except for emergency services, benefits in an HMO option are provided only when covered services are provided by an HMO participating provider.
- SAVE Affidavit: If an alien registration number is provided in the SAVE Affidavit, GMA will verify the number through the federal SAVE program. If SAVE is unable to verify an enrolled employee's lawful presence in the United States, the employee's health benefits will be terminated retroactively.

ATTACH REQUIRED DOCUMENTS:

- If adding Employee for the first time: **SAVE Affidavit** of employee's lawful presence in U.S. & identification document from Attorney General list in Affidavit
- If adding Spouse or Stepchild: Copy of **Marriage Certificate**. *You must notify GMA immediately if you divorce from this Spouse.*
- If adding any Child: Copy of **Birth Certificate**. Also (if applicable): **Court Order** (adoption, legal guardianship, NMSN), **Disability Form** if Child is age 26 or older. *You must notify GMA immediately when the legal guardianship or disability ends.*
- If you previously declined coverage and are adding anyone mid-year: **Loss of Coverage letter** or notice of new eligibility for **State Premium Assistance Subsidy**
- If dropping coverage due to divorce, end of legal guardianship, end of disability status - Copy of **Divorce Decree,** Copy of **Court Order** showing expiration of legal guardianship, documentation showing date disability status ended.
- If changing/correcting name, birth date, SSN: an official document showing correct information (**Social Security Card, Driver's License, Birth Certificate**).

Section 7: Employee & Employer Affirmations

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* _____

Employer Affirmation *

☐ *I affirm that the information provided in this form is complete and accurate, and that required documents have been provided. If an employee is enrolling for the first time, I affirm that the employee listed above meets the requirements for eligibility as set forth in the Employer's applicable Declaration Pages.*

Employer Signature* _____ Date* _____