FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM

DEPARTMENT OF FINANCE
141 PRYOR STREET SW STE 7001, ATLANTA, GA 30303

(404) 612-7606 (Pension Office)
(404) 612-1312 (E-Fax)

401 (A) DEFINED CONTRIBUTION

PRIOR TO YOUR LAST DAY ON DUTY, THE PENSION OFFICE NEEDS:

- COPY OF YOUR BIRTH CERTIFICATE
- COPY OF SPOUSE'S BIRTH CERTIFICATE AND SOCIAL SECURITY CARD
- COPY OF CHILDREN BIRTH CERTIFICATE
  (*MINOR CHILDDREN UNDER THE AGE OF 18 AND/OR COLLEGE STUDENTS UP TO AGE 26*)
- COPY OF MARRIAGE CERTIFICATE
- COPY OF YOUR MEDICARE CARD, IF APPLICABLE (DISABLED OR AGE 65 OR OVER)
- COPY OF SPOUSE'S MEDICARE CARD, IF APPLICABLE (DISABLED OR AGE 65 OR OVER)
- COPY OF TERMINATION/RETIREMENT LETTER SUBMITTED TO YOUR MANAGER OR DEPARTMENT HEAD
- HEALTH INSURANCE ENROLLMENT FORM
- AUTHORIZATION AGREEMENT FOR ACH DEBITS
- TERMINATION /RETIREMENT NOTIFICATION FORM
- COPY OF SIGNED/SAVED AFFIDAVIT (IF ENROLLING INTO HEALTH BENEFTIS)

PLEASE NOTE: Payout of your accrued vacation, holiday and/or comp time will not be directly deposited. You will receive a paper check. Please advise your payroll rep if you want your check mailed or if you will pick up your check. After you have been paid out your accrued leave balances and are off payroll, your separation date and vesting percentage will be sent to Mass Mutual and your application for retirement and ancillary benefits will be reviewed for approval by Internal Audit. The 401 (A) plan's Retirement Committee meets every quarter. You will receive a letter from Employee Benefits confirming your retirement, health benefits coverage and cost and the effective date premiums will be debited from your bank account.

Mass Mutual is the 401 (A) plan's administrator. For the disbursement of your funds, please contact a representative at 1-888-526-6905 and request for the Benefits Elections Form.

Retiree Health Benefits Information:
As you transition from active employee to retiree, you may receive a letter from Blue Cross Blue Shield of Georgia advising you that your health benefits has expired as an active employee and that you may apply of COBRA. Since you are retiring from the county, **please disregard that letter**. Your retiree health benefits will be effective the month after your health benefits expire as an active employee. Also, please bear in mind that during this transition, there will be a delay in your health benefits coverage. ***Therefore, after you have received your final pay for your accrued leave balance of vacation, holiday and/or comp time from the county. Please try to schedule your doctor's appointments after the 10th of the following month of your final pay check from the county.*** ER appointments will be handled on a case by case basis. If you have any questions regarding this process, please call …. **Pension Benefits at (404) 612-4228, option # 2.**

IMPORTANT INFORMATION FOR CASH WITHDRAWAL/ROLLOVERS FROM TIAA-CREF 457B DEFERRED COMPENSATION ACCOUNTS

- TIAA-CREF requires that Fulton County provide the date of separation for participants before they can release their 457B Account Funds. Fulton County will NOT provide separation dates until employees receive their last check as an ACTIVE employee (Pay Out of Leave Check/Final Check) from Fulton County, and are placed off payroll. The Personnel Department staff updates the Payroll System with employees' employment status as being separated and Off Payroll approximately one (1) month after the last date of employment.

- Employees that are planning to retire or EXIT Fulton County and request to have their Pay Out of Leave Check (last check as an ACTIVE Employee) deferred into their 457 Account need to meet with finance Department Payroll Staff only to verify the Pay Out of Leave Check documents are complete for processing last check as an ACTIVE employee with Fulton County.

- Employees requesting to make Federal and State Tax Adjustments with their Pay Out of Leave Check/Final Check need to meet with Payroll Staff only to verify (ALL) tax documents are complete for processing last check as an active employee with Fulton County. Please contact 404-612-7668 or 404-612-7677, if you have any questions.

- Loan and Unforeseeable Emergency Withdrawals – employees must contact TIAA-CREF directly. TIAA-CREF determines if an employee is eligible NOT Fulton County. TIAA-CREF is Fulton County's Plan Administrator. The call center telephone number is 800-842-2252.

RETIREE

Fulton County, Georgia

Group Life Insurance Enrollment/Change Form

LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH

Coverage Selection:

_____	Basic Life Coverage	$10,000	No Retiree Cost

(Check Only One Dependent Life Option)

_____	Dependent Life	$10,000 per dependent	$.85 per month
_____	Dependent Life	Waived or Not Applicable	No Retiree Cost

Eligible Dependent: (Spouse or Child up to age 26)

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

BENEFICIARY DESIGNATION: If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds with 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 beneficiary (ies). If you list benefit percentages, the total must equal 100%. (Retiree is the beneficiary of proceeds from dependent coverage.)

FIRST NAME LAST NAME	SOCIAL SECURITY #	RELATIONSHIP & ADDRESS	BENEFITS %
Primary			
Primary			
Contingent			
Contingent			

I HEREBY REQUEST TO BE INSUREED AND AUTHORIZE DEDUCTIONS, IF ANY, FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLLAT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONARIRE MAY BE REQUIRED. I UNDERSTAND THAT ANY INDIVIDUAL DEPENDENT CAN ONLY BE COVERED ONCE IN THIS GROUP LIFE INSURANCE PLAN.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime and subjects such person to criminal and civil penalties. INFORMATION ON THIS FORM WILL OVERRIDE ANY PRIOR SELECTION OR DESIGNATION FOR THE POLICY (IES) LISTED ABOVE.

RETIREE SIGNATURE _____ DATE _____ /_____/_____

CHECK YOUR RETIREMENT PLAN

401A (New Plan) _____ **(DB) Defined Benefit (Old Plan)** _____

2020 Retiree/Beneficiary Annual Enrollment Form

INFORMATION ABOUT YOU

Retiree Name (First Name, Last Name):		**Social Security #:**
Are you age 65 or older / Medicare Eligible: ☐ Yes ☐ No		
Retiree Home Address:		
Street:	*City:*	
	State:	*Zip:*
Home Phone:	**Cell Phone:**	**Email:**
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced	**Date of Hire:**____/____/____	**Date Retired:**____/____/____
Are *you* eligible for Medicare? ☐ Part A / Effective date:____/____/____	☐ Part B / Effective date:____/____/____	
Is *your spouse* eligible for Medicare? ☐ Part A / Effective date:____/____/____	☐ Part B / Effective date:____/____/____	
Is your or your spouse's Medicare coverage related to end-stage renal disease? ☐ Yes ☐ No		

YOUR HEALTH PLAN OPTIONS

Medical Plan Coverage Tier (Select One):

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren)
☐ Family ☐ Waive Coverage

Medical Plan Options—Retirees Under Age 65:
(Non-Medicare) SELECT ONE MEDICAL PLAN

☐ HSA Plan (Anthem BlueCross BlueShield)
☐ HMO Plan ((Anthem BlueCross BlueShield) - **NEW**
☐ POS Plan (BlueCross BlueShield of Georgia)
☐ HMO Plan (Kaiser Permanente)

Medical Plan Options—Retirees Age 65 or Older:
(Medicare) SELECT ONE MEDICAL PLAN

☐ Basic Medicare Advantage Plan (Aetna) *
☐ Enhanced Aetna Medicare Advantage Plan (Aetna)*
☐ Medicare Indemnity Plan (Anthem BlueCross BlueShield)
☐ Medicare HMO Plan (Anthem BlueCross BlueShield)
☐ PPO Plus Plan (Anthem BCBS —current participants only) Closed

*** To enroll in the Basic Aetna Medicare Advantage Plan or the Enhanced Aetna Medicare Advantage Plan for the first time, please contact Aetna directly: (800) 307-4830.**

Dental Plan (SELECT ONE DENTAL PLAN)

☐ Comprehensive Dental PPO Plan ☐ Dental HMO Plan - Primary Dentist Office ID_____(Required)

Dental Plan Coverage Tier (Select One):

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren)
☐ Family ☐ Waive Coverage

Vision Plan Coverage Tier (Select One):

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren)
☐ 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?	Currently covered by Medicare?	Dependent Coverage Option (If Retiree is enrolled in Aetna Medicare Advantage Plan)
Self				☐ Yes	☐ Yes	
Spouse				☐ Yes	☐ Yes	**Anthem** ☐ Medicare Indemnity Plan ☐ Medicare HMO Plan
Child				☐ Yes	☐ Yes	
Child				☐ Yes	☐ Yes	
Child				☐ Yes	☐ Yes	

If any of your dependents listed above live at an address that is different than yours, please complete the following:

Name(s)	**Address(es)**

When enrolling dependents for the first time, you must submit with this enrollment form supporting documentation appropriate for the relationship of the dependent to you (e.g., marriage certificate, birth certificate, adoption placement papers, court-ordered child health coverage support affidavit, physician verification of permanent disability).

IF YOU ARE DECLINING COVERAGE

By completing this section, I acknowledge that I was given the opportunity to enroll for 2020 Fulton County health care coverage and am choosing not to enroll in one or more of the above benefit plans. I understand that if my dependents or I wish to enroll at a later date for any of the coverage(s) I have declined, I / they will be required to submit a new Enrollment Form and coverage may be subject to late enrollee provisions, as allowed by law and as directed by my employer.

Reason for refusal: (Please check all that apply)

☐ Other group coverage sponsored by my employer
☐ Other group coverage sponsored by my spouse's employer
☐ Other group coverage sponsored by another organization
☐ Other reasons (Please explain below)

FOR OTHER COVERAGE

Carrier:	Plan Number:
Telephone Number:	

Retiree Signature	**Date**

I hereby authorize a deduction to be made from my pay or drafted from my bank account on file (if applicable) as my share of the premium cost, as authorized by the Fulton County Board of Commissions. I certify the above information is true and correct and I am entitled to the coverage requested. I declare that all statements and information made hereon are complete and true to the best of my knowledge, I understand that any misstatements or omissions may void all coverage applied for any member on this application on a retroactive basis for up to two (2) years from the contract effective date.

Return completed form with any required supporting documentation postmarked by **October 18, 2019** to

Fulton County Pension Office
141 Pryor Street S.W. Suite 7001
Atlanta, GA 30303

FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM

DEPARTMENT OF FINANCE
141 PRYOR STREET SW STE 7001, ATLANTA, GA 30303

Dear Retiree:

Congratulations on your retirement from Fulton County Government! This is to inform you that as a retiree enrolled in the 401A Defined Contribution Plan, you are required to have the funds for your premiums automatically debited from your checking/savings account to continue health insurance. Please complete and sign the information below and include a voided check or a depository slip for savings account and submit to our office with your retirement package.

If you have any questions about this process, please call Pat Williams at (404) 612-4228. Thanks for your cooperation in this matter.

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEBITS (ACH DEBITS)

COMPANY NAME: Fulton County Government

I hereby authorize Fulton County Government, hereinafter called **COMPANY**, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my

Please Select One:

_____ Checking _____ Savings Account

Indicated below and the depository named below, hereinafter called **DEPOSITORY**, to debit and/or credit the same to such account in amount of **$**_____ monthly that is due for my ancillary benefits. I authorize the adjustment of this amount for any increase or decrease in premiums.

Please complete and attach a voided check or a deposit slip for your savings account.

DEPOSITORY NAME: _____ BRANCH: _____

CITY: _____ STATE: _____ ZIP: _____

TRANSIT/ABA NO.: _____ ACCOUNT NO.: _____

This authority is to remain in full force and effect until **COMPANY** has received written notification from me of its termination in such time and in such manner as to afford **COMPANY** and **DEPOSITORY** a reasonable opportunity to act on it.

NAME: _____ SSN: _____
(PLEASE PRINT)

DATE: _____ SIGNATURE: _____

TELEPHONE #: _____

FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM

DEPARTMENT OF FINANCE
141 PRYOR STREET SW STE 7001, ATLANTA, GA 30303

Date: _____

To: **PENSION DIVISION – 401 (A) PLAN**

Subject: **Termination/Retirement Notification Request**

I am resigning or retiring from Fulton County and request that my termination date and vesting percentage are provided to Mass Mutual for the processing of my 401(A) funds.

LAST DAY WORKED: _____

DATE OF FINAL PAY OUT OF ACCRUED LEAVE (VAC, HOL, COMP) _____

Mass Mutual will receive notification of your separation date after you have been paid out the accrued leave balance that is due to you.

For the distribution of your funds, contact MASS MUTUAL at **404-612-9048**.

Employee Name: _____

SS#: _____

Telephone#: _____

Mailing Address: _____

Employee Signature: _____

Fulton County Retirement System
Department of Finance
141 Pryor Street, Suite 7001
Atlanta, GA 30303

Pension Office: (404) 612-7606 Fax: (404) 612-1312

Retiree Information

Retiree Name: _____

Email: _____

Emergency Contact #1 Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Home Phone: ( ) _____ Cell Phone: ( ) _____

Relationship: _____ Email: _____

Emergency Contact #2 Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Home Phone: ( ) _____ Cell Phone: ( ) _____

Relationship: _____ Email: _____

COMPLIANCE WITH "SAVE" STATUTORY REQUIREMENTS

Fulton County Government is required to comply with the enacted State Law that requires the County's participation in Systematic Alien Verification for Entitlements ("SAVE") Program. The SAVE Program is a federal Initiative designed to aid benefit-granting agencies in determining an applicant's Immigration status, and thereby ensure that only entitled applicants receive federal, state or local benefits and licenses. As required by Georgia Security and Immigration Compliance Act of 2006, as amended, every agency administering or providing Public Benefits is responsible for requiring that applicants for public benefits execute a sworn affidavit to verify lawful presence in the United States.

All permanent employees and retirees receiving retirement, disability, and/or health Insurance benefits are required to complete the "**Affidavit Verifying Eligibility Status for Public Benefits Form**" enclosed in this letter. This affidavit must be executed in front of a notary and employees must **return original notarized affidavit with** a copy of one (1) secure and verifiable document from the list below:

SECURE AND VERIFIABLE DOCUMENTS

- *An Unexpired* **United States Passport or Passport Card**
- *An Unexpired* **United States Military Identification Card**
- *An Unexpired* **Driver's License** Issued by one of the United States
- *An Unexpired* **Identification card** Issued by the United States
- *An Unexpired* **Tribal Identification Card** of a federally recognized Native American Tribe
- *An Unexpired* **US Permanent Resident Card or Alien Registration Receipt Card**
- *An Unexpired* **Employment Authorization Document** that contains a photograph of the bearer
- *An Unexpired* **Merchant mariner Document or Credential** Issued by U.S. Coast Guard
- *An Unexpired* **Free and Secure Trade (FAST) card**
- *An Unexpired* **Certificate of Citizenship** Issued by the United States Department of Citizenship
- *An Unexpired* **Certificate of Naturalization** issued by the United States Department of Citizenship
- *An Unexpired* **Passport Issued by a Foreign Government** provided that such passport is accompanied by a United States Department of Homeland Security ("DHA") Form I-94A, DHS Form I-94W, or other federal form specifying on individual's lawful presence Under Federal Immigration law.

PENSION BENEFITS OFFICE

Fulton County Government
Affidavit Verifying Eligibility Status for Public Benefit(s)

Pursuant to the *Georgia Security and Immigration Compliance Act* of 2006 (Senate Bill 529.GSICA), every agency administering or providing public benefits is responsible for determining U.S. citizenship or lawful alien status of applicants for said benefits. (O.C.G.A. § 50-36-1)

By executing this affidavit under oath, as an applicant for a retirement, disability, and/or health insurance benefits, the undersigned applicant verifies one of the following with respect to his/her application for a public benefit from Fulton County Government.

1. _____ I am a United States citizen.
2. _____ I am a legal permanent resident of the United States.
3. _____ I am a qualified alien or non-immigrant under the *Federal Immigration and Nationality Act with* an alien number issued by the Department of Homeland Security or other federal immigration agency.

   My alien number issued by the Department of Homeland Security or other federal immigration agency is: _____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure verifiable document listed below, as required by O.C.G.A..§ 50-36-1(e)(1), with this affidavit.

The following list of secure and verifiable documents, published under the authority of O.C.G.A.§ 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- *An Unexpired **United States Passport or Passport Card***
- *An Unexpired **United States Military Identification Card***
- *An Unexpired **Driver's License** issued within the United States*
- *An Unexpired **identification card** issued within the United States*
- *An Unexpired **Tribal Identification Card** of a federally recognized Native American Tribe*
- *An Unexpired **US Permanent Resident Card or Alien Registration Receipt Card***
- *An Unexpired **Employment Authorization Document** that contains a photograph of the bearer*
- *An Unexpired **Merchant Mariner Document or Credential** issued by U.S. Coast Guard*
- *An Unexpired **Free and Secure Trade (FAST) Card***
- *An Unexpired **Certificate of Citizenship** issued by the United States Department of Citizenship*
- *An Unexpired **Certificate of Naturalization** issued by the United States Department of Citizenship*
- *An Unexpired **Passport issued by a Foreign Government** provided that such passport is accompanied by a United States Department of Homeland Security ("DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law.*

The secure and verifiable document provided with this affidavit can best be classified as:
(list document and provide a copy) _____

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20 and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____ (state)

_____
Signature of Applicant

_____
Printed Name of Applicant

Subscribed and sworn before me on this the

_____ day of _____, 20_____

Notary public: _____

My commission expires: _____