2026 Part B Affidavit

ALL MEDICARE-ELIGIBLE PARTICIPANTS MUST COMPLETE AND RETURN THIS FORM.

Each year during Open Enrollment, any Fulton County Medicare-eligible retiree, beneficiary or dependent **MUST** certify whether they are currently participating in Medicare Part B. **If you are Medicare-eligible, you should enroll in Medicare Part B!** If you don't return the 2026 Part B Affidavit, with a copy of your Medicare card, you will lose the Medicare subsidy currently provided to you by the County for 2026.

MEMBER INFORMATION		
Retiree/Beneficiary name:		
Retiree type: ☐ 401(A) retiree (New Plan) OR ☐ Defined Benefit retiree (Old Plan)		
Retiree/beneficiary SSN: _____ - _____ - _____	Gender: ☐ Male ☐ Female	
Date of birth: _____ / _____ / _____	Phone:	
Street:	City:	
	State:	Zip:

If dependent is Medicare-eligible, please list.	
Dependent name:	**Dependent SSN:** _____ - _____ - _____

MEDICARE ELIGIBILITY		
I hereby certify that my current enrollment in Medicare is below.		
Retiree:	Medicare Part A: ☐ Yes ☐ No Effective date: _____ / _____ / ____	Medicare Part B: ☐ Yes ☐ No Effective date: _____ / _____ / _____
Retiree Medicare Number:		
Dependent:	Medicare Part A: ☐ Yes ☐ No Effective date: _____ / _____ / ____	Medicare Part B: ☐ Yes ☐ No Effective date: _____ / _____ / _____
Dependent Medicare Number:		

Retiree/beneficiary signature: _____ Date: _____

Important! If at any time during the enrollment year you drop or stop your Part B coverage, YOU MUST NOTIFY THE FULTON COUNTY RETIREE BENEFITS TEAM IMMEDIATELY.

Please return this completed form, along with a copy of your Medicare card, to Fulton County Retiree Benefits. To ensure timely processing, you are encouraged to email your completed form.

Email: retireebenefits@fultoncountyga.gov

Mail: Fulton County Pension Office, 141 Pryor Street SW, Suite 7001, Atlanta, GA 30303