FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM

Department of Finance
141 Pryor Street SW, Suite 7001
Atlanta, GA 30303
Pension Office: 404-612-7606
Fax: 404-730-7809

RETIREMENT INFORMATION

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 CHILDREN UNDER AGE 18 AND/OR COLLEGE STUDENTS UP TO AGE 25*)
- 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)*

PLEASE COMPLETE THE FOLLOWING ENCLOSED FORMS:

- PENSION APPLICATION
- BENEFICIARY FORM
- DEDUCTION TO MAINTAIN IN RETIREMENT
  (INCLUDE DEPOSIT SLIP FOR CREDIT UNION DEDUCTIONS)
- DIRECT DEPOSIT FORM (*INCLUDE A VOID CHECK*)
- W-4 TAX WITHHOLDING FORM
- HEALTH INSURANCE ENROLLMENT FORM
- LIFE INSURANCE ENROLLMENT CARD
- COPY OF SIGNED/SAVED AFFIDAVIT

PLEASE NOTE: Payout of your accrued vacation, holiday and/or comp time will not be direct deposited. You will receive a paper check. Please advise your payroll rep if you want your check mailed or if you will pick up. After you have been paid out your accrued leave balances and are off payroll, your Pension will be presented to the Pension Board for approval. The Pension Board meets the 2nd Wednesday of each month and Pension checks are paid on the 1st of each month. If the 1st falls on a weekend, checks will be paid on the previous business day.

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 for 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…..
Verna Thomas at 404-612-4228

FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM

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

APPLICATION FOR RETIREMENT

☐ STANDARD... ☐ AGE PENALTY... ☐ BENEFICIARY... ☐ DISABILITY... ☐ LINE OF DUTY DISABILITY

The undersigned does hereby apply for retirement benefits under the _____ Law, effective _____.

Name _____ SS# _____

Address _____

_____ Telephone No. _____

Department _____ Last Day on Duty _____

Date of Birth _____ Date of Marriage _____

Employees Association (maintain membership) Yes ☐ No ☐

Name of Spouse _____

Spouse Date of Birth _____ SS# _____

Sworn to and subscribe before me this

_____d ayof _____20____

_____ _____

Notary Public Applicant Signature

CERTIFICATE OF AUDITOR

For pension is _____years of age, has regularly contributed to the Pension Fund of said County pursuant to law, and that they have been in the employ of Fulton County as represented in their petition _____ years which may include prior service credit, according to Fulton County records, and that if it is satisfactorily shown to the Pension Board that the facts stated in the petition are true, then the Pension Board of Fulton county is authorized to grant to the petitioner a monthly pension in the amount of $_____per month, effective_____, 20_____.

APPROVED BY:

_____ _____

Attorney AUDITOR

Date: _____ Date: _____

FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM
DEPARTMENT OF FINANCE, 141 PRYOR ST., STE 7001, SW, ATLANTA, GA 30303

BENEFICIARY FORM

NAME _____ SOCIAL SECURITY NO. _____

DEPARTMENT _____ DATE OF BIRTH _____

EMPLOYMENT DATE _____

BENEFICIARY STATEMENT FOR...

SINGLE STATUS EMPLOYEES AND EMPLOYEES WITH LESS THAN TEN YEARS CREDITABLE SERVICE

In the event of my death before retirement and before becoming eligible for my beneficiaries to receive pension benefits, I direct that a lump sum payment of my contributions (or any undistributed balance thereof) be made to:

_____

_____

Please include name(s), address and social security numbers of Beneficiary
If there are no spouse or minor children, you can say "Executor of my Estate"...include the person(s) name and address

EMPLOYEES WITH TEN OR MORE YEARS OF CREDITABLE SERVICE

Your spouse and/or minor children under age 18 are automatically beneficiaries under the pension plan. It is the duty of each employee to notify the Pension division of any change in the status of beneficiaries, such as birth of children, death of spouse or divorce.

Name of Spouse _____ SS# _____

Spouse's Date of Birth _____ Date of Marriage _____

Minor Children Under Age of 18 Years:

Name	Date of Birth	Social Security #

Signature _____ Date _____

Witness _____ Date _____

FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM
DEPARTMENT OF FINANCE, 141 PRYOR ST., STE 7001, SW, ATLANTA, GA 30303

(ACH CREDITS) PENSION PAYROLL DEPOSIT AUTHORIZATION FORM

COMPLETE AND RETURN TO THE PENSION DIVISION

PLEASE INCLUDE A VOID CHECK FOR PROCESSING

WRITE "VOID" ON CHECK

BANK _____

CITY _____

RETIREE NAME _____

BANK ABA NO. _____

ACCOUNT NUMBER _____

I hereby authorize Fulton County Pension Board and the Bank listed to deposit my net pension pay automatically to my account each pay day. This authorization will remain in effect until I have provided written notification to cancel.

_____

SIGNATURE

_____

DATE

WITHHOLDING ALLOWANCE CERTIFICATE

Name _____ Social Security Number _____

Street Address _____ ☐ Single ☐ Married

City, State, Zip Code _____ ☐ Head of Household

FEDERAL

1. Withhold Federal Tax from my pension ☐ Yes ☐ No
2. Total number of allowances you are claiming..... _____
3. Additional amount, if any, you want deducted from your pension..$_____

STATE

1. Withhold Georgia Tax from my pension ☐ Yes ☐ No
2. Total number of allowances you are claiming..... _____
3. Additional amount, if any, you want deducted from your pension..$_____

Signature _____ Date _____

FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM
DEPARTMENT OF FINANCE, 141 PRYOR ST., STE 7001, SW, ATLANTA, GA 30303

DEDUCTIONS TO MAINTAIN IN RETIREMENT

(COMPLETE AND RETURN WITH APPLICATION)

CREDIT UNION DEDUCTIONS

(INCLUDE DEPOSIT SLIP FOR PROCESSING)

A) ASSOCIATED FEDERAL CREDIT UNION (CRED1)

YES ☐

NO ☐

AMOUNT $_____

B) EXCEL FEDERAL CREDIT UNION (CRED2)

YES ☐

NO ☐

AMOUNT $_____

C) CITY OF ATLANTA (CRED3)

YES ☐

NO ☐

AMOUNT $_____

_____

SIGNATURE

_____

DATE

FULTON COUNTY

CHECK YOUR RETIREMENT PLAN

401A (New Plan) ☐ (DB) Defined Benefit (Old Plan) ☐

2019 Retiree 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:
SELECT ONE MEDICAL PLAN

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

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

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

*** 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	
Child				☐ Yes	☐ Yes	☐ Medicare Indemnity Plan
Child				☐ Yes	☐ Yes	☐ Medicare HMO Plan
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 2019 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 Commissioners. 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.

2019 Retiree Annual Enrollment Form

RIGHTS AND OBLIGATIONS

I hereby apply for myself and my eligible family members for the coverage specified in the Contract between my Group/Employer and BlueCross and BlueShield of Georgia, Aetna Medicare Advantage PPO, Kaiser Foundation Health Plan of Georgia HMO, Aetna Health Dental PPO or HMO, or EyeMed Vision (hereinafter referred to as the Plans).

I understand and agree that the effective date of coverage will be governed by the stipulations of the Group Application and the Master Group Contract under which this application is made. I understand that membership will continue according to the terms of the contract between the employer and the Plans. I hereby authorize the employer to periodically deduct any charge due from me hereunder and to remit same to the Plans along with any contribution due from the employer.

I hereby authorize any hospital, physician, psychiatrist, psychologist, counselor, psychiatric hospital or other provider, dispenser of prescription drugs, appliances, ambulance service or any person or any institution rendering services to me or members of my family, if covered hereunder, to furnish the Plans all requested information concerning treatment, advice, psychiatric care or medical care for previous or future conditions, illnesses or disabilities.

I declare that all statements made hereon including the information provided on the front of this application are complete and true to the best of my knowledge and belief, and agree that the Plans may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or false information has been submitted, personally assuming liability for reimbursement to the Plans for any benefit payment made on behalf of such family member. After this contract has been in force for a period of two (2) years during the lifetime of the insured, it shall become incontestable as to the statements in the applications. I understand that I am responsible for giving notice to my Group/Employer of any changes in my status and that of my family members that affect coverage.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. Your answers are required to determine if you qualify for coverage. Plans are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help obtain additional medical data from physicians or hospitals.

ALL DATA IS CONFIDENTIAL. Plans are required by law to keep such data confidential. It will be seen only by their employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. Plans may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of standard business practice or required by law.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information. You also have the right to send a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of information practices, please contact the applicable carrier:

- BlueCross and BlueShield of Georgia, Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908–7368
- Aetna, Inc., RT-52, 151 Farmington Avenue, Hartford, Connecticut 06156
- Kaiser Foundation Health Plan of Georgia, Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305
- EyeMed Vision Care, 4000 Luxottica Place, Mason, OH 45040.

2018 Retiree Annual Enrollment Form

RIGHTS AND OBLIGATIONS

I hereby apply for myself and my eligible family members for the coverage specified in the Contract between my Group/Employer and BlueCross and BlueShield of Georgia, Aetna Medicare Advantage PPO, Kaiser Foundation Health Plan of Georgia HMO, Aetna Health Dental PPO or HMO, or EyeMed Vision (hereinafter referred to as the Plans).

I understand and agree that the effective date of coverage will be governed by the stipulations of the Group Application and the Master Group Contract under which this application is made. I understand that membership will continue according to the terms of the contract between the employer and the Plans. I hereby authorize the employer to periodically deduct any charge due from me hereunder and to remit same to the Plans along with any contribution due from the employer.

I hereby authorize any hospital, physician, psychiatrist, psychologist, counselor, psychiatric hospital or other provider, dispenser of prescription drugs, appliances, ambulance service or any person or any institution rendering services to me or members of my family, if covered hereunder, to furnish the Plans all requested information concerning treatment, advice, psychiatric care or medical care for previous or future conditions, illnesses or disabilities.

I declare that all statements made hereon including the information provided on the front of this application are complete and true to the best of my knowledge and belief, and agree that the Plans may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or false information has been submitted, personally assuming liability for reimbursement to the Plans for any benefit payment made on behalf of such family member. After this contract has been in force for a period of two (2) years during the lifetime of the insured, it shall become incontestable as to the statements in the applications. I understand that I am responsible for giving notice to my Group/Employer of any changes in my status and that of my family members that affect coverage.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. Your answers are required to determine if you qualify for coverage. Plans are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help obtain additional medical data from physicians or hospitals.

ALL DATA IS CONFIDENTIAL. Plans are required by law to keep such data confidential. It will be seen only by their employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. Plans may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of standard business practice or required by law.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information. You also have the right to send a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of information practices, please contact the applicable carrier:

- BlueCross and BlueShield of Georgia, Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908–7368
- Aetna, Inc., RT-52, 151 Farmington Avenue, Hartford, Connecticut 06156
- Kaiser Foundation Health Plan of Georgia, Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305
- EyeMed Vision Care, 4000 Luxottica Place, Mason, OH 45040.

RETIREE

Fulton County, Georgia

revised 04/13

Group Life Insurance Enrollment/Change Form

RETIREE NAME LAST | FIRST | MIDDLE INITIAL | SEX ☐M ☐F | 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 moth

☐ Dependent Life Waived or Not Applicable No Retiree Cost

Eligible Dependents: (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 will 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	BENEFIT %
Primary			
Primary			
Contingent			
Contingent			

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FOR MY SHARE OF THE COST OF THE BENFITS 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 ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNARIRE 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 insurance 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 _____/_____/_____

FULTON COUNTY GOVERNMENT
COMPLIANCE WITH "SAVE" STATUTORY REQUIREMENTS

Fulton County 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 verifying the employee's 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**". 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.

Failure to comply could result in delay or suspension of employees' benefits. If you have questions, please contact Anthony Muhammad via email anthony.muhammad@fultoncountyga.gov or call at (404) 612-7675 or (404) 612-7605.

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 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 ("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.*

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 by 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 ("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: _____