



**STATE HEALTH BENEFIT PLAN (SHBP)
2014 ACTIVE EMPLOYEE TOBACCO USERS CESSATION AFFIDAVIT FORM**

Policyholder/Plan Member Name _____

Social Security Number _____

Check the applicable box below:

If you think you might be unable to complete the tobacco cessation wellness coaching program, you might qualify for an opportunity to avoid the tobacco surcharge by different means. Contact Healthways at 888-616-6411 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

I hereby certify that all covered members have not used any tobacco products within the last 60 days. I have attached confirmation of completion of the online Well-Being Assessment and Letter of Completion confirming that all covered members that previously used tobacco products have completed the surcharge removal requirements as outlined in the 2014 Active Employee Tobacco Users Cessation Policy.

OR

I hereby certify that all covered members that use tobacco products have completed the surcharge removal requirements as outlined in the 2014 Active Employee Tobacco Users Cessation Policy. I have attached confirmation of completion of the online Well-Being Assessment and Letter of Completion for the wellness coaching program.

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than \$1,000 or imprisonment for not less than one and no more than five years, I will have to pay the applicable premium surcharge, and that I may be subject to cancellation of medical coverage under the terms of the plan and/or disciplinary action up to and including termination of my employment, if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health (DCH) regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature _____ Date _____

Note: Once you have read and signed this affidavit you must submit it to your payroll location benefit coordinator, who will complete the required deduction information and submit to SHBP for processing. If this form is received without a signature, all applicable boxes checked and the letter of completion, it will be returned to your payroll location and will delay processing.

Department/School System Use Only		
Payroll Location #	Date of first deduction	Deduction Amount