# CERTIFICATION
# TO
# THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH, STATE HEALTH BENEFIT PLAN (SHBP)

**Name of Organization: _____**

**State of Incorporation: _____**

I am requesting access on behalf of _____ (Full Name of "Organization") to be used for receipt and submission of information in response to the Georgia Department of Community Health, State Health Benefit Plan (SHBP) Invitation for Proposals (IFP). This Organization is an entity qualified in the State of Georgia to offer certain health benefit services and holds all applicable licenses, registrations, and permits to operate in the State of Georgia. This Organization will comply with all requirements and restrictions concerning the receipt and handling of information, including but not limited to confidential data, from SHBP in order to submit a response to the IFP. Furthermore, this Organization will comply with all requirements concerning the submission of a response to the IFP. Aon Hewitt Health Resource acts as the authorized designee of SHBP concerning the IFP.

***(Select one or both Certification Statements, as applicable)***

**Pharmacy Benefits Management and Claims Administration**

___ I certify that I am duly authorized on behalf of the Organization to provide this Certification and that the Organization satisfies the following mandatory requirements, as specified in the IFP, offering Pharmacy Benefits Management and Claims Administration for the State of Georgia, State Health Benefit Plan:

**Mandatory Requirements**

- Offeror must have provided Pharmacy Benefits Management and Claims Administration (on a self-funded basis) for at least three (3) of the last five (5) years to at least one (1) client with a minimum client size of 400,000 covered lives and an entire book of business of at least 1.2 million covered lives as evidenced by corporate resume and client references

*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 not more than five years, or both, if I knowingly and willfully make a false or fraudulent statement or representation to the Department of Community Health regarding the above information pursuant to O.C.G.A. Section 16-10-20***

***I further understand that the information in this Certification is subject to verification by the DCH or designee, and that findings of inaccuracies will constitute sufficient cause for disqualification of the Organization from consideration of further evaluation.***

***(Signatures on the following page)***

**Print: _____** _____
Name Title

**Signature: _____** _____
Date

*The Certification must be executed by a Senior executive or officer of the Organization (i.e., President, Vice-President, or Chief Executive Officer of a corporate entity, Senior Partner or Member of a Partnership or LLC).