



**STATE HEALTH BENEFIT PLAN (SHBP)  
2012 RETIREES NON-TOBACCO USERS AFFIDAVIT FORM**

**Policyholder/Plan Member Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Health Plan Option:** (Circle One) Standard Cigna HDHP, Wellness Cigna HDHP, Standard Cigna HMO, Wellness Cigna HMO, Standard Cigna HRA, Wellness Cigna HRA, Standard UHC HDHP, Wellness UHC HDHP, Standard UHC HMO, Wellness UHC HMO, Standard UHC HRA, Wellness UHC HRA

**Check all of the following:**

- I hereby certify that all covered members have not used any tobacco products within the past 60 days
- I hereby certify that all applicable covered members have completed a health assessment during this plan year
- I hereby certify that all applicable covered members have completed an online or telephonic wellness program with the above health plan
- I understand that as a State Health Benefit Plan member I have the responsibility to read the current Decision Guide and the Summary Plan Description of my chosen health plan option
- I understand it is my responsibility to access the website **OR** complete a personalized change form each year during the Retiree Option Change Period (ROCP) to make elections and answer the surcharge questions to prevent default surcharges
- I also understand that this document must be completed, all boxes checked and returned to SHBP, P.O. Box 1990, Atlanta, GA. 30301-1990. The effective date of the change will be dependent upon the date SHBP receives this form. No refund in premium(s) will be made for any previous deductions that included the surcharge amounts.

**I do hereby attest that the above information is true and correct to the best of my knowledge. I further understand that I will permanently lose my SHBP coverage 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. I also understand that I will not be eligible to re-enroll unless I return to work in a benefits eligible position in which SHBP coverage is offered.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Note: Once you have read and signed this affidavit you must submit it to SHBP. If this form is received without a signature and all boxes checked, it will be returned to you for completion and will delay processing.**