



STATE HEALTH BENEFIT PLAN (SHBP) REMOVAL OF SPOUSAL SURCHARGE AFFIDAVIT

Policyholder/Plan Member Name _____

Social Security Number _____

Check appropriate box, sign and date this form. You must submit it to your payroll location/benefit coordinator to have the required deduction information completed at the bottom of this form. You will be charged the surcharge for a minimum of one month. Retro-deductions will not be refunded.

- My spouse is enrolled in his/her employer's health coverage. A copy of the insurance card, letter from the insurer, or letter from the employer is attached. Any correspondence from the insurer or employer must be on company letterhead
- My spouse is employed but is not eligible for or not offered health benefits through his/her employer. A letter, on the employer's letterhead with an employer contact person's name and phone number, that states my spouse's name and that my spouse is not offered health benefits is attached
- My spouse is employed and also covered through his/her employer under the State Health Benefit Plan. A copy of my spouse's insurance card is attached
- My spouse is unemployed and not covered under any other employer-sponsored health coverage. A copy of the prior year's federal tax return (with financial information blocked out) showing unemployed status is attached. If recently unemployed, a signed, notarized statement is attached stating the name of my spouse and a statement attesting that my spouse is currently unemployed and not covered under any other employer-sponsored health coverage

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, or both, and I may lose health coverage for one year, if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health 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 to have the below required deduction information completed. If this form is received without a signature and the appropriate box checked, 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