Georgia Department of Community Health

STATE HEALTH BENEFIT PLAN (SHBP)
REMOVAL OF SPOUSAL SURCHARGE AFFIDAVIT
Effective January 1, 2009

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

☐ 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