



**STATE HEALTH BENEFIT PLAN (SHBP)  
2011 TOBACCO USERS CESSATION AFFIDAVIT FORM  
(RETIREES UNDER AGE 65)**

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

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

**Health Plan Option: (Circle One) CIGNA HDHP, CIGNA HMO, CIGNA HRA, UHC HDHP, UHC HMO, UHC HRA**

**Check one of the following:**

- I hereby certify that all covered members have not used any tobacco products within the last 60 days. In addition, I have attached a certificate of completion affirming that all covered members that previously used tobacco have completed the telephonic tobacco cessation health coaching program with the above health plan

**OR**

- I hereby certify that all covered members have not used any tobacco products for 61 days or more. In addition, I have attached a certificate of completion (from my healthcare vendor) affirming that all covered members that previously used tobacco have completed an online or telephonic wellness program with the above health plan

**Check all of the following:**

- I understand that as a SHBP member I have the responsibility to read the current Decision Guide and the Summary Plan Description (SPD) of my chosen health benefit option
- I understand it is my responsibility to access the retiree option change period website each year 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 SBHP, P.O. Box 1990, Atlanta, GA 30301-1990 in order to remove the tobacco surcharge currently being applied to my health coverage premium. In addition, if I or any covered dependents resume using any tobacco products after completing the telephonic tobacco cessation health coaching program, I will notify SHBP in writing. No refund in premiums will be made for any previous deductions that included the surcharge amounts. Section 125 rules for Cafeteria Plans require all changes in premium are prospective.

**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.**

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

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