



**STATE HEALTH BENEFIT PLAN (SHBP)
2014 ACTIVE EMPLOYEE NON-TOBACCO USERS AFFIDAVIT FORM**

Policyholder/Plan Member Name: _____

Social Security Number: _____

Check both of the following:

If you think you might be unable to complete the wellness coaching program, you might qualify for an opportunity to avoid the tobacco surcharge by different means. Contact Healthways at 888-616-6411 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

I hereby certify that all covered members have not used any tobacco products within the last 60 days. In addition, I have attached confirmation of completion of the online Well-Being Assessment and Letter of Completion confirming that all covered members that previously used tobacco products have completed the surcharge removal requirements as outlined in the 2014 Active Employee Non-Tobacco Users Cessation Policy.

I understand that this document must be completed, both boxes checked and returned to my payroll location benefit coordinator, who will complete the required deduction information and submit to SHBP for processing.

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 \$1000 or imprisonment for not less than one and no more than five years, I will have to pay the applicable premium surcharge, and that I may be subject to cancellation of medical coverage under the terms of the plan and/or disciplinary action up to and including termination of my employment, if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health regarding information reported on this form or other information or other information pursuant to O.C.G.A. Section 16-10-20.

Signature _____ **Date** _____

Note: Once you have read and signed this Affidavit Form you must submit it to your payroll location benefit coordinator, who will complete the required deduction information and submit to SHBP for processing. If this Affidavit Form is received without a signature, all boxes checked and the necessary certificate(s) of completion and confirmation(s) of completion 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