



**STATE HEALTH BENEFIT PLAN (SHBP)
2014 RETIREES TOBACCO USERS CESSATION AFFIDAVIT FORM**

Policyholder/Plan Member Name _____

Social Security Number _____

Check the applicable box below:

If you think you might be unable to complete the tobacco cessation 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 a 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 Retiree Tobacco Users Cessation Policy.

OR

- I hereby certify that all covered members that use tobacco products have completed the surcharge removal requirements as outlined in the 2014 Retiree Tobacco Users Cessation Policy.** I have attached confirmation of completion of the online Well-Being Assessment and Letter of Completion for telephonic tobacco cessation coaching.

Check all of the following:

- I hereby certify that all applicable covered members have completed a Well-Being assessment during this plan year
- I also understand that this document must be completed, all applicable boxes checked and returned to SHBP, P.O. Box 1990, Atlanta, GA 30301-1990 in order to remove the tobacco surcharge currently being applied to my health coverage premium

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 _____