

Please read the Terms, Conditions and Instructions on the back of this form prior to completing the form.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

State Health Benefit Plan - Retiree /Surviving Spouse Form

Mail to:
State Health Benefit Plan
P. O. Box 1990
Atlanta, Georgia 30301-1990

I. MEMBER IDENTIFICATION SSN _____ - _____ - _____ Date of Birth ____/____/____ Male Female Telephone Number _____
Last Name _____ First _____ Middle Initial _____ Street Address _____ Apt/Box/Route _____ City _____ State _____ Zip _____

II. RETIREMENT SYSTEM USE ONLY: Retirement System No. _____ Retiree Number _____ Date of First Deduction ____/____/____

III. COVERAGE ACTION Which Retirement System will provide benefits? _____
 Enrollment in Retirement System Last Payroll Deduction Date ____/____/____ (does not apply to surviving spouse)
 Service Retirement Disability Retirement Surviving Spouse/Dependent Social Security # of Deceased _____ - _____ - _____
 Change of Coverage Option
 Change of Coverage Tier (*) Date of Event ____/____/____ Check box that best describes the reason for this membership action and give the date of the event. These actions require supporting documentation:
 Marriage Acquisition of Dependent Divorce Death of Dependent Change in Employment Status Affecting Eligibility for Health Coverage
 (*)When changing the coverage tiers, you cannot add your dependent(s) back unless you experience a Qualifying Event. The retirement of your spouse or the increase in his/her premium is NOT a QE.

IV. COVERAGE OPTION (Check your choice of the coverage options below): Acronyms: HRA (Health Reimbursement Arrangement), HDHP (High Deductible Health Plan), And HMO (Health Maintenance Organization)
A. Select Vendor (choose only one): CIGNA/ Humana UnitedHealthcare (UHC)
B. Select a Medicare Advantage PPO Option (if eligible): MA PPO Standard MA PPO Premium (UHC only)
C. Select Option for family members who are NOT eligible for Medicare Advantage Options OR who are eligible, but choose instead to pay the unsubsidized premium:
 HRA Wellness HDHP Wellness HMO Wellness Tricare Supplement (under age 65 only)
 HRA Standard HDHP Standard HMO Standard
Note: Anyone 65 or older who is not enrolled in an MA PPO Option will pay an unsubsidized premium for health insurance. That means the premium cost will be much higher.

FOR INTERNAL USE ONLY: WELLNESS: CIGNA: HRA – C3 HDHP – C5 HMO – C1 STANDARD: CIGNA: HRA – C2 HDHP – C4 HMO – C0
 UHC: HRA – U3 HDHP – U5 HMO – U1 UHC: HRA – U2 HDHP – U4 HMO – U1

V. Coverage Tier: Choose one of the options below - Acronyms: Tobacco Surcharge (Tob SC) Spouse (Sp)
 10 You 90 You + Sp 94 You + Child(ren) 96Family (You + Sp + Children)
 40 You + Tob SC 91 You + Sp + Tob SC 95 You + Child(ren) + Tob SC 97 Family + Tob SC

NOTE: Please see reverse side of form for details regarding removal of the tobacco surcharge.

VI. DEPENDENTS AND MEDICARE: See reverse side of this form for dependent documentation requirements. Coverage for all dependents requires submission of documents and coverage will not be updated until documentation is received and approved. Use the abbreviations provided to show the relationship of each dependent:

Relationship Codes: SP for your wife or husband NC for your natural or adopted child SC for your stepchild LC for Legal Guardianship

Full name of persons to be covered Last First MI	Relationship (See above)	Sex (Circle)	Date of Birth MO DA CCYR	Social Security Number (REQUIRED)	Medicare Number	Medicare A Effective Date	Medicare Part B Effective Date	Medicare Part D Effective Date
RETIREE (SAME AS ABOVE)	SELF							
		M F						
		M F						

VIII ATTESTATION: I have read and understand the eligibility rules of the State Health Benefit Plan, which are set forth in the current Decision Guide and SHBP regulations. I affirm that, if applicable, I am enrolling only eligible dependents. I agree to abide by the Terms, Conditions and Instructions provided on the back of this form. I understand that my eligibility for the State Health Benefit Plan is contingent on continuous coverage. I agree to pay directly for any lapse in coverage caused by administrative delay. If I have selected an Option that ceases operation, I authorize the State Health Benefit Plan to automatically transfer my coverage to the default option, unless I make another coverage selection as allowed by the Plan. I do hereby attest that the above information is true and correct to the best of my knowledge. I understand that if I misrepresent eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against me, including but not limited to terminating coverage (for the member and his/her dependent(s) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the member or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law. I understand that if I fail to answer a surcharge question, the applicable surcharges will apply for the next plan year or until I complete the surcharge removal process. Intentional misrepresentation in response to surcharge questions will result in the loss of your SHBP coverage permanently.

Signature of Retiree/Surviving Spouse: _____

Date: _____

Terms, Conditions and Instructions - Retiree/Surviving Spouse Form

General Information: This form must be used by a retired or retiring State Health Benefit Plan (SHBP) member, or surviving spouse/dependent(s), who will be receiving an annuity from one of the following retirement systems: Teachers' Retirement System (TRS), Employees' Retirement System (ERS) or Public School Employees' Retirement System (PSERS), Legislative Retirement System, Superior Court or District Attorneys' Retirement System or any local school system's retirement system. The annuity must be a sufficient amount to pay the premium deduction for health benefit coverage. Effective date of the change is dependent on payroll deadlines and information provided. Refunds will not be issued for late submission or incorrect information. You must apply for continued coverage for yourself and covered dependents within 60 days of the date your active coverage ends. Members initially retiring in TRS, ERS and PSERS do not need to complete this form to continue their coverage into retirement as it is automatically moved to retiree coverage. Members will receive a letter from SHBP advising of this change and give them the opportunity to change elections or discontinue coverage.

Tobacco Surcharge: If any covered member of your family is unable to achieve tobacco-free status due to a medical condition, you must submit a letter from the treating physician and complete an alternative program in order to prevent imposition of the tobacco surcharge or remove the tobacco surcharge. Information on having the surcharges removed is available at www.dch.georgia.gov/shbp. You may also contact your healthcare vendor for information.

Use this form for the following reasons: • Qualifying Events • Change of address and other information • Transfer from active to retiree health coverage (not required for retirement in TRS, ERS or PSERS) Review the instructions and complete sections I, III, IV, V, and Section VII if covering dependent(s). If you are not enrolled in one of the MA PPO, MA split options or you are paying the unsubsidized premium for your health insurance, you will also need to answer the tobacco and spousal surcharge questions in Section VI. Please read the Attestation in Section VIII carefully, then sign and date the form. Incomplete forms **will not** be returned for completion.

Enrollment for Coverage: Only eligible individuals may be enrolled in the SHBP. Eligibility requirements, and requirements for continuing coverage as a retiree or surviving spouse are fully described in official plan documents, which include the most recent Decision Guide, Summary Plan Description and current regulations. These documents may be viewed at www.dch.georgia.gov/shbp. Coverage for a retired employee, teacher or surviving spouse/dependents must be continuous. If the annuity payment from your retirement system does not begin immediately, your coverage will be interrupted. To protect your eligibility for coverage, the SHBP eligibility office should be contacted at (800) 610-1863 for instructions concerning alternative payment provisions allowed by the Plan.

The surviving spouse married to member more than one year may elect to continue coverage for themselves and eligible surviving dependent children. No additional dependents may be added to the coverage (No Exceptions). Dependent children may continue coverage under the surviving spouse contract until they no longer meet the eligibility requirements (See Eligible Dependents). The surviving spouse married to member less than one year is eligible for 36 months under COBRA provisions.

A surviving spouse who is also eligible for coverage under the Plan as a retiree or employee may elect coverage as a surviving spouse or employee. Such persons cannot elect double or dual coverage under these separate provisions of the Plan. The surviving spouse may resume coverage upon termination of employment if otherwise ineligible for coverage as a retiree.

Surviving dependent children who are receiving an annuity from the retirement system may continue coverage until they no longer meet the eligibility requirements. Surviving dependent children not receiving an annuity from the retirement system are eligible for 36 months under COBRA provisions.

Dependent Documentation Requirements. Be sure to circle the proper code in Section VII to describe the dependent's relationship to you and provide the documentation listed below.

SP - Certified copy of marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse/ financial information blacked out.

NC – Natural - Certified copy of birth certificate listing parents by name (birth card issued by hospital is acceptable for new births); Adopted - Certified copy of court documents establishing date of adoption; certified or notarized legal documents establishing the date of placement for adoption if adoption is not yet finalized and certified copy of birth certificate or other proof of date of birth

SC - Certified copy of birth certificate showing your spouse is natural parent and certified copy of marriage license showing natural parent is your spouse or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse/financial information blacked out

LC - Certified copy of court documents stating the dates on which the legal guardianship begins and ends and a certified copy of the birth certificate or other proof of the child's date of birth.

NOTE: Dependents will not be verified as having coverage until the required documentation is received and entered. Children who meet SHBP eligibility requirements are eligible for coverage until the end of the month in which they turn 26 unless a disabled child.

NOTE: Non-payment of premiums for PeachCare is not a qualifying event and does not allow you to add your child(ren) back to SHBP coverage.

Retirees who return to state employment in a benefits-eligible position must discontinue retiree coverage and elect coverage as an employee. When active employment ends, the retiree **MUST** notify SHBP within 60 days to resume coverage as a retiree and premiums will be deducted from his/her annuity.

Eligibility to Change Coverage: Covered retirees and surviving spouses/dependents may change to any available option during the annual Retiree Option Change Period. However, retirees and surviving spouses/dependents **cannot** enroll for health coverage during this period.

Change of Option: At the time of enrollment as a retiree or upon reaching age 65 and electing Medicare, or if the annuity is not sufficient to cover the premiums, a change may be made to any available option.

Change of Tier or drop SHBP Coverage: A change to Single Tier or discontinuation is allowed at anytime. **However, if you drop the coverage, you may never get it back unless you return to work in a SHBP benefits eligible position.**

Qualifying Events: Retirees are allowed to increase coverage tiers to cover a newly acquired dependent only in limited circumstances; i.e. marriage, birth of a child, adoption of a child, start of legal guardianship, or receipt of a qualified medical child support order (QMCSO) provided the request is filed no later than 31 days following the event. Coverage changes made outside the annual Retiree Option Change Period will be effective the first day of the month following the appropriate payroll deduction. (Newborns may be covered from date of birth if appropriate deduction is taken and request of coverage is reported with 31 days of birth).

Medicare Information—At age 65, retirees may enroll in a Medicare Advantage Option (Medicare Part B enrollment required) and continue to pay a State-subsidized premium. All other benefit options are unsubsidized and much more expensive. Accurate Medicare information must be provided by the member. You must attach a copy of each Medicare card to this form.