



**STATE HEALTH BENEFIT PLAN (SHBP)
2013 RETIREES TOBACCO USERS
CESSATION AFFIDAVIT FORM**

Policyholder/Plan Member Name _____

Social Security Number _____

Health Plan Option: (Circle One) Cigna Standard HDHP, Cigna Wellness HDHP, Cigna Standard HMO, Cigna Wellness HMO, Cigna Standard HRA, Cigna Wellness HRA, UHC Standard HDHP, UHC Wellness HDHP, UHC Standard HMO, UHC Wellness HMO, UHC Standard HRA, UHC Wellness HRA

Check the applicable box below:

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 health assessment and certificate of Completion confirming that all covered members that previously used tobacco products have completed the wellness program requirements as outlined in the 2013 Retiree Tobacco Users Cessation Policy.

OR

I hereby certify that a covered member of my family is unable to achieve tobacco-free status due to a medical condition and that all other covered members have not used tobacco products within the last 60 days. In addition, I have attached a certificate of completion (from my healthcare vendor) for the telephonic wellness program, confirmation of completion of the online health assessment and a letter from the treating physician stating the medical reason why the covered member is unable to achieve a tobacco-free status.

Check all of the following:

- I hereby certify that all applicable covered members have completed a health 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. In addition, if I or any covered dependents resume using any tobacco products, I will notify SHBP in writing. No refund in premiums will be made for any previous deductions that included the surcharge amounts.

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 _____