



**STATE HEALTH BENEFIT PLAN (SHBP)
2012 ACTIVE EMPLOYEE NON-TOBACCO USERS 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 all of the following:

- I hereby certify that all covered members have not used any tobacco products within the past 60 days
- I hereby certify that all applicable covered members have completed a health assessment during this plan year
- I hereby certify that all applicable covered members have completed an online or telephonic wellness program with the above health plan
- I understand that as a State Health Benefit Plan member I have the responsibility to read the current Decision Guide and the Summary Plan Description of my chosen health plan option
- I understand it is my responsibility to access the Open Enrollment 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 my payroll location benefit coordinator in order to have the tobacco surcharge removed. The effective date of the change will depend upon the payroll schedule for my employer. No refund in premium(s) will be made for any previous deductions that included the surcharge amounts. Section 125 of the Internal Revenue Service (IRS) rules for Cafeteria Plans require that all changes in premiums be prospective.

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 that \$1000 or imprisonment for not less than one and no more that five years, or both and I may lose health coverage for one year, 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. I also understand that I will not be eligible to re-enroll unless I return to work in a benefits eligible position in which SHBP coverage is offered.

Signature _____ **Date** _____

Note: Once you have read and signed this affidavit you must submit it to your payroll location benefit coordinator to have the required deduction information completed. If this form is received without a signature and all boxes checked, it will be returned to you for completion and will delay processing.

Department/School System Use Only		
Payroll Location #	Date of first deduction	Deduction Amount