

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**  
**State Health Benefit Plan**  
**P.O. Box 1990, Atlanta, GA 30301**  
**Active Employee Discontinuation of Health Benefit Coverage**

Please type or print clearly in ink and return to your HR Department.

Please read the Terms, Authorization, Conditions and Instructions on the back of this form. Complete Section I, check the appropriate statement in Section III and sign and date this form in Section IV. Your signature certifies that you understand that your subsequent enrollment with the State Health Benefit Plan will be restricted to the HRA or HDHP options. If you are re-enrolling within the same Plan Year because you have experienced a qualifying event, you will only be able to enroll in the tier and coverage you had at the time coverage was lost.

**I. MEMBER IDENTIFICATION:** SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Street Address \_\_\_\_\_ Apt/Box/Route \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code 5 digits) \_\_\_\_\_ Daytime Telephone Number (\_\_\_\_) \_\_\_\_\_  
Area Code

**Department Information only**

Payroll Location No. \_\_\_\_\_ Unit/School \_\_\_\_\_ Last Date of Deduction \_\_\_\_/\_\_\_\_/\_\_\_\_

**III. Discontinuation Reason (check only one reason)**

- 1. Open Enrollment Discontinuation**  
 During this Open Enrollment period, I choose to discontinue all coverage under the State health Benefit Plan.
- 2. Discontinuation Due to Coverage through Marriage or Spouse's Employment**  
 I (and all my eligible dependents) have, within the past 31 days, become eligible for coverage through my spouse's employment. This eligibility is based upon: (check one):  
 New employment       Marriage (Date) \_\_\_\_/\_\_\_\_/\_\_\_\_       Open enrollment election

**Complete the appropriate section below:**

- Spouse's coverage through employment IS under the State Health Benefit Plan** through \_\_\_\_\_ (employer). The contract number (SSN) is \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Spouse's coverage through employment is NOT under the State Health Benefit Plan.** Documentation from the spouse's employer is required and must include date of employment, effective date of coverage, and names of persons covered. Discontinuation will not become effective until documentation is received and approved by the Plan.
- 3. Medicare Discontinuation**  
 As an active employee who is now eligible for Medicare, I choose to discontinue all coverage with the State Health Benefit Plan. I also understand that in order to have coverage under the SHBP as a retiree, coverage must be in effect at the time of my retirement.

**IV.**

**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 also understand and agree to the Terms and Conditions listed on the reverse side of this form.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **TERMS, CONDITIONS AND INSTRUCTIONS**

### **Discontinuation of Health Benefit Coverage**

#### **General Information**

This form must be completed by a member/employee who discontinues coverage under the State Health Benefit Plan (SHBP). Complete Section I, review the Statement and Certifications in Section III and sign in Section IV. Note if you discontinue coverage, your next opportunity to enroll will be during the annual Open Enrollment Period unless you experience a qualifying event that allows you to pick up coverage. See the information below for details.

#### **Enrollment in the SHBP**

Enrollment in the SHBP is limited to the Open Enrollment Period, except under the following conditions:

- Upon employment, an employee has the opportunity to **ENROLL** for coverage to begin the first day of the month following completion of one full calendar month of employment, subject to the conditions of the Plan. See the Summary Plan Description for pertinent conditions at [www.dch.georgia.gov](http://www.dch.georgia.gov).
- Upon the loss of member's/employee's or dependent's health benefit coverage through Medicaid, Medicare, the group or COBRA coverage of the spouse or former spouse, a member/employee has the opportunity to **ENROLL** for coverage or **CHANGE** tiers provided the request is filed no later than 31 days following the event. (*Attach a letter from Medicaid, Medicare, or the spouse's or former spouse's employer giving the reason the group coverage was terminated, the type of coverage, date of coverage termination and list of covered subscribers/dependents*).
- Upon the acquisition of coverage under a new spouse's group plan or your spouse's employment, you may **CHANGE** tiers or **DISCONTINUE** coverage provided all dependents covered under the SHBP contract are covered under the new contract. The request for the change of coverage must be filed within 31 days following the acquisition of coverage. (*Attach a letter from the spouse's employer giving the date of employment, effective date of coverage, and name(s) of person(s) covered.*)
- Upon the acquisition of a dependent by marriage, birth, adoption, a qualified medical child support order (QMCSO) or for certain other changes in family status (*see the Eligible Dependents Section*), a **CHANGE** in tiers is allowed provided the request is filed no later than 31 days following the event.

#### **Open Enrollment Period**

Open Enrollment (OE) is a time each year when active employees may **ENROLL** or **CHANGE** option or type of coverage without regard to medical underwriting, subject to the provisions of the Plan. Active employees who are eligible to participate in the State Health Benefit Plan shall have an annual Open Enrollment period. The Open Enrollment period consists of a 30-day period beginning no earlier than October 1 and ending no later than November 30. Each year in advance of the period, the Commissioner of the Department of Community Health will announce the exact dates.

***NOTE: Retirees may continue coverage at the time of retirement but are not allowed to enroll for coverage.***

**Authorization:** I choose to discontinue all coverage under the State Health Benefit Plan. I understand if I discontinue coverage at this time, I cannot re-enroll for coverage under any option of the Plan until the next Open Enrollment Period except under the conditions stated on the reverse side of this form. I also understand that my options may be limited to the HRA and HDHP for the first Plan Year of coverage should I enroll at a future time. Exception: If you are re-enrolling within the same Plan Year, you will only be able to enroll in the tier and coverage you had at the time coverage was lost.