

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

**Georgia Department of Community Health
Membership/Dependent and Miscellaneous Update**

Please type or print clearly in ink. This form must be submitted by your employer.

I. Member Identification			
Social Security Number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name	First	Initial	
Apartment/Box/Route			
Street Address			
City, State		Zip Code (5-digit + 4-digit)	
County of Residence	County Code	Date of Birth	
		Month	Day Year
Daytime Telephone Number ()		Sex (Check one)	
Area Code	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

II. Coverage Action		
* These Selections Require Supporting Documentation		
<input type="checkbox"/> Enrollment	<input type="checkbox"/> Change of Option	
<input type="checkbox"/> Transfer to new Department or School System	<input type="checkbox"/> Change of Type	
	<input type="checkbox"/> New ID Card	
Check the box that best describes the reason for this membership action and give the date of the event.		
<input type="checkbox"/> New Hire	<input type="checkbox"/> Acquisition of Dependent	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Pregnancy/Birth*	
<input type="checkbox"/> Marriage* - Date: _____	<input type="checkbox"/> Adoption*	
<input type="checkbox"/> Divorce*	<input type="checkbox"/> Child Support Order*	
<input type="checkbox"/> Death of Dependent	<input type="checkbox"/> Other*	
<input type="checkbox"/> Loss of All Eligible Dependents	<input type="checkbox"/> Loss/Acquisition of Spouse's Group Coverage*	
<input type="checkbox"/> Deletion of Dependents (See back of form)		
<input type="checkbox"/> Change in Employee ID	<input type="checkbox"/> Date of Birth Correction	
<input type="checkbox"/> Address/Phone Number Change		
<input type="checkbox"/> Name Change - Old Name: _____		
<input type="checkbox"/> Social Security Number Change (attach copy of card)		
Eligibility date in this location if new hire or transfer, otherwise, date of event:	Month	Day Year

III. Coverage Read about the Health Benefit Options available to you in the Health Decision Guide. Check your choice of one of the coverage options. Also check your choice of coverage tier.		
Option		
<input type="checkbox"/> PPO (58)	<input type="checkbox"/> PPO CCO (68)	
<input type="checkbox"/> BlueChoice (06)	<input type="checkbox"/> BlueChoice CCO (16)	
<input type="checkbox"/> CIGNA (05)	<input type="checkbox"/> CIGNA CCO (15)	
<input type="checkbox"/> Kaiser (07)	<input type="checkbox"/> Kaiser CCO (17)	
<input type="checkbox"/> United Healthcare (03)	<input type="checkbox"/> United Healthcare CCO (13)	
<input type="checkbox"/> Indemnity (89)		
<input type="checkbox"/> *TRICARE Supplement (02) DEERS # _____ (required)		
<input type="checkbox"/> High Deductible Plan (08)	<input type="checkbox"/> High Deductible Plan CCO (18)	
Tier		
<input type="checkbox"/> Single (10)	<input type="checkbox"/> Family (20)	
IV. Department/School System Use Only		
Date of First Deduction		Dept./School System No.:
Month	Day Year	
		Unit/School:

V. Your response is required for the following questions:

- *A) Have you or any of your covered dependents used any tobacco products in the previous 12 months? [Y] [N] If Yes, a monthly surcharge applies.
- *B) If spouse is selected for coverage, please answer the following question(s): If questions 2 and 3 are "No" a monthly surcharge applies.

Spouse Question 1: Is your spouse eligible for health benefit coverage through his/her employment?

Yes - Please answer Spouse Question 2 No - Questions finished

Spouse Question 2: Is your spouse enrolled in health benefit coverage through his/her employment?

Yes - Questions finished No - Please answer Spouse Question 3

Spouse Question 3: Is your spouse eligible for SHBP coverage through his/her employment?

Yes - Questions finished No - Questions finished

*NOTE: surcharges are not applicable for Tricare Supplement Coverage.

- to Remove surcharges see Reverse side of form

VI. Dependents (Complete only if you have family coverage)

See reverse side of this form for eligibility requirements. Coverage for dependents requires submission of additional documents; (coverage will not begin until documentation is received and approved.) Use the abbreviations provided to show the relationship of each dependent.

Action		All These Relationships Require Supporting Documentation							
A to add	C to correct	D to delete	SP for your wife or husband	NC for your natural child	SC for your stepchild	LC Legal Child			
Action (Circle)	Full name of spouse and eligible dependents to be covered	Relationship (Circle)	Sex (Circle)	Date of Birth			Social Security Number (Required)	Reason for Deletion from Coverage (If deleting)	Event Date
	Last	First	Initial	Month	Day	Year			
A/C/D	Last	First	Initial	SP SC					
				NC LC	M F				
A/C/D	Last	First	Initial	SP SC					
				NC LC	M F				
A/C/D	Last	First	Initial	SP SC					
				NC LC	M F				

VII Authorization: I have read and agree to abide by the Terms, Conditions, and Instructions provided on the back of this form. I hereby authorize my employer to deduct each month from any wages due me the premium amount and any applicable surcharges applicable to the coverage I have selected. I understand that the selected coverage will be effective the first of the month following the appropriate deduction. I also understand that I cannot change or cancel coverage until the next Open Enrollment Period except under limited conditions. I understand that if I terminate my employment and am re-hired during the same Plan Year, SHBP regulations require that I maintain the same option. If I have selected an HMO option, I understand that if I do not work or live in the service area of that HMO, I must use that HMO's pre-selected providers for medical benefits. If I have selected an HMO and the HMO ceases operation, I authorize my employer to automatically transfer my coverage to the PPO unless I make another coverage selection as allowed by the Plan. I understand that if I fail to answer a question concerning one of the surcharges, I will automatically be charged the applicable surcharge. Surcharges will apply to the next plan year. I hereby certify that the above information and any supporting document(s) are true and correct. I understand that misrepresentation or falsification will subject me to penalties and possible legal action.

Signature of Member/Employee: _____ Date: _____

TERMS, CONDITIONS, AND INSTRUCTIONS

General Information

Please review all State Health Benefit Plan (SHBP) communications and materials prior to completion of this form. Copies of this material may be obtained from your employer's benefit coordinator at your payroll location or at www.dch.georgia.gov website. It is essential that you carefully read all your materials and answer all the surcharge questions. Failure to do so could have a financial impact on your premium.

This form is to be used by employees for the following reasons listed below:

- To enroll in the SHBP
- Transfer coverage to a new employer
- Change Coverage Option and/or Tier
- Request an ID card
- Update dependent information (add/delete/change)
- Name/Address/Social Security number change

You should read this side of the form and then complete Sections I, II, III, V and, if Family coverage is selected, Section VI. Incomplete forms will be returned for completion. Read the Authorization in Section VII carefully, then sign and date the form. The effective date of coverage is dependent upon your employment date, the qualifying event date and/or your payroll deduction for coverage. Refunds cannot be issued for late submission of Change requests or submission of incorrect or incomplete information.

Enrollment for Coverage

Enrollment for coverage or Change in Option or Tier is limited to the annual Open Enrollment Period, except under limited qualifying events. A detailed list of the events and documentation that is required is provided in the State Health Benefit Plan Summary Plan Document or at www.dch.georgia.gov. Coverage for enrollments or changes made outside the Open Enrollment Period will be effective the first day of the month following the appropriate payroll deduction. **NOTE:** Coverage will not be effective if the employee/subscriber is not "at work" on the date that coverage would otherwise become effective. "At work" means that you are either performing your normal duties or you are on paid leave.

Surcharge Questions

Spousal Surcharge:

A spousal surcharge will be added to your monthly premium if you elected to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived. You will automatically be charged the surcharge if you fail to answer all questions concerning the surcharge. The surcharge will apply to your premium until the next Plan Year.

Tobacco Surcharge:

A surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months.

How to Remove Surcharges

Spousal Surcharge

If your spouse becomes covered by his/her employer's health benefit plan, the surcharge can be removed if you make the request and provide proof within 31 days of the effective date of the other coverage.

Tobacco Surcharge

- You must attend a smoking cessation program sponsored by Kaiser or the American Cancer Society.
- You will receive an attendance certification form. You and the representative should both sign the form.
- You should complete the appropriate Tobacco Affidavit Form available from the SHBP at www.dch.georgia.gov.
- Give both forms to your employer's Benefit Coordinator at your payroll location to complete the required deduction information.

The change in premiums will be effective based on the payroll schedule of your employer. No refund in premium will be made for previous health deductions that included the surcharge amounts. IRS rules do not allow premium changes to be made retroactively.

Open Enrollment Period

Open Enrollment is a time each year when members/employees may enroll or change option or tier of coverage without regard to medical underwriting, subject to the provisions of the Plan. Active employees who are eligible to participate in the SHBP have an annual Open Enrollment period. The Open Enrollment period consists of a 30-day period beginning in mid-October and ending in mid-November. Each year in advance of the period, the Commissioner of the Department of Community Health will announce the exact dates.

Eligible Dependents

Be sure to use the proper code in Section VI to describe the dependent's relationship to you. The following describes the dependents that are eligible under this Plan and the documentation requirements for each:

- A) SP - Your legal spouse as defined by Georgia law - Copy of certified marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse) with financial information blacked out and showing the spouse's signature.
- B) NC - Natural Child - Copy of the certified birth certificate showing parents names.
- C) SC - Step Child - Copy of certified birth certificate showing your spouse is the natural parent: AND Copy of certified marriage

license showing the natural parent is your spouse; AND Notarized statement that the dependent lives in your home at least 180 days per year.

- D) LC - Other child (which includes adoptions and temporary and permanent guardianship) - Copy of court decree showing your financial responsibility for the dependent; AND copy of certified birth certificate; AND notarized statement that dependent lives in your home on a permanent basis.
- E) Children meeting the requirements listed above are eligible for coverage until the end of the month in which they turn 19 or until the end of the month in which they marry whichever comes first. Dependent students that meet the requirements are eligible for coverage until age 26 provided they are registered students in regular full-time attendance at an accredited school, college or university, or institution for the training of nurses. A Student Status information form is available from your employer's benefit coordinator at your payroll location and must be completed with the required documentation attached and forwarded to the SHBP for review and processing. Dependent children ages 19 through 25 who are employed in benefit eligible positions are not eligible for coverage regardless of student status.

VERY IMPORTANT: DEPENDENTS MUST BE VERIFIED PRIOR TO THEIR COVERAGE EXPIRATION DATE. Students, Disabled Children and Legal Children recertification must be received before the coverage expiration date. The dependent will not be eligible after the expiration date, if the documentation is not received before their coverage expires. You may add the dependent during the next Open Enrollment period.

Penalties for Misrepresentation

If a SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participant, including but not limited to termination of coverage (for the participant and his or her dependent(s)) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries where 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.

In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law. Intentional misrepresentation in response to surcharge questions will have significant consequences. You will automatically lose SHBP coverage for 12 months beginning on the date that your false response is discovered.