

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**  
**State Health Benefit Plan**  
**Retiree July 1, 2009 Enrollment (Option) Form**

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

**Use this form only if you wish to change options and return it in the envelope provided  
by May 15, 2009 along with the Medicare enrollment information.**

**I. Member Identification:**

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

**II. Coverage Action - Change of Option for currently enrolled plan members and covered dependents:****Check the box(es) that best describes the reason for this action:**

- Member enrolling in Medicare Part B for a July 1, 2009 effective date.
- Spouse enrolling in Medicare Part B for a July 1, 2009 effective date.
- Member is not enrolled in Medicare B effective July 1, 2009; changing option due to premium increase.
- Spouse is not enrolled in Medicare B effective July 1, 2009; changing option due to premium increase.
- I wish to change to single coverage effective July 1, 2009. **I UNDERSTAND THAT DEPENDENTS MAY ONLY BE ADDED IN THE FUTURE AS A RESULT OF A QUALIFYING EVENT.**
- I wish to drop my SHBP coverage. **I UNDERSTAND I WILL NO LONGER BE ELIGIBLE FOR SHBP COVERAGE AS A RETIREE.**

**III. Options – Choose one of the options below (do NOT check more than one box below):**

Acronyms: HRA (Health Reimbursement Arrangement), HDHP (High Deductible),  
HMO (Health Maintenance Organization), PPO (Preferred Provider Organization)

**CIGNA**

- 35 Choice Fund (HRA)
- 85 Open Access Plus (HDHP)
- 05 Open Access Plus In Network (HMO)
- 55 Open Access Plus (PPO)
- 25 Medicare Access Plus RX (Medicare Advantage)

**UNITEDHealthCare**

- 31 Definity (HRA)
- 08 HDHP
- 03 Choice HMO
- 58 PPO
- 23 Medicare Direct (Medicare Advantage)

**KAISER (For current Kaiser Members Only)**

- 07 HMO
- 27 Senior Advantage

**IV. Medicare Information for enrollment in Part B:**

**PLEASE ATTACH A COPY OF YOUR OR YOUR SPOUSE'S MEDICARE CARD OR A COPY OF ACKNOWLEDGEMENT LETTER SHOWING HIC # CONFIRMING NEW ENROLLMENT IN MEDICARE PART B FOR SHBP TO ADJUST YOUR PREMIUM. THE HIC # MUST BE PROVIDED TO THE CENTER OF MEDICARE SERVICES (CMS) BEFORE ENROLLMENT IN A MEDICARE ADVANTAGE PLAN CAN BE APPROVED BY CMS FOR THE NEW ENROLLEE.**

**V. Attestation:**

I have read and agree to abide by the terms, conditions, authorization and instructions provided on the back of this form. 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 than \$1,000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make false or fraudulent statements or representation to the State Health Benefit Plan regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature of Retiree: \_\_\_\_\_

Date: \_\_\_\_\_

**TERMS, CONDITIONS, AUTHORIZATION AND INSTRUCTIONS**  
**July 1, 2009 Retiree Age 65+ Medicare Part B Enrollment Form**

**General Information:** This form is to be used only if you wish to change health plan options. You are not required to change options, but if you enroll in Medicare Part B and/or your new health premium changed as a result of the new Medicare Part B policy, you may change options, if desired.

Please review all State Health Benefit Plan (SHBP) communications and materials prior to completion of this form. Plan information is available on the SHBP Web site at [www.dch.georgia.gov](http://www.dch.georgia.gov). It is essential that you carefully read all your materials, answer all the questions, and submit complete Medicare Part B enrollment information. **Failure to do so will financially impact your premiums.**

You should read this side of the form and then complete Sections I, II and III. Read the Attestation in Section V carefully, then sign and date the form. **Please submit the form to SHBP no later than May 15, 2009.** This will allow sufficient time to adjust your premium and timely notification to the appropriate retirement system, if applicable, of the new premium deduction from your check. This will also allow adequate time for you to receive your new insurance card, if applicable, by July 1, 2009.

**Change of Coverage:** Change in Option is limited to the annual Retiree Open Change Period, except under limited qualifying events.

**Penalties for Misrepresentation:** If a SHBP participant misrepresents eligibility information when applying for coverage, during a 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 dependents(s) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his/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. 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.

**Authorization:** I have read and agree to abide by the terms, conditions, authorization and instructions provided on this form. If the premium amount is deducted from my monthly check, I hereby authorize SHBP to adjust the deduction for 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 my coverage option until the next Retiree Option Change Period except under limited conditions. If I have selected an HMO option, I understand that, if I do not live in the service area of that HMO, I must remain in that option and I must use the HMO's pre-selected providers for medical benefits. If I have selected an HMO and the HMO ceases operations, I authorize SHBP to automatically transfer my coverage to the United HealthCare Definity (HRA) unless I make another coverage selection as allowed by the plan. 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.