



**STATE HEALTH BENEFIT PLAN (SHBP)
2013 ACTIVE EMPLOYEE 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 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 Active Employee 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 coaching 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 tobacco-free status.

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, 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** _____

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

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