GEORGIA DEPARTMENT OF COMMUNITY HEALTH
State Health Benefit Plan
Enrollment and Miscellaneous Update Form

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

I. Member Identification SSN ☐☐☐-☐☐-☐☐☐☐

Last Name First Middle Initial

_____

Apt/Box/Route

_____

Street Address

_____

City, State Zip Code (5-digit + 4 digit)

_____-_____

Date of Birth

____/___/_____ ☐ Male ☐ Female

Daytime Telephone Number

(_____)_____

II. Department/School System Use Only

Payroll Location Number _____

Unit/School_____

Event Date _____/_____/_____

Date of First Deduction _____/_____/_____

III .Coverage Action

These Selections Require Supporting Documentation

□ Enrollment □ Change of Option □ Change of Tier

Check the box that best describes the reason for action:

□ Open Enrollment □ Marriage □ Birth/Adoption
□ Divorce □ Child Support Order □ Death of Dependent
□ Loss/Acquisition of Spouse Group Coverage
□ Loss of All Eligible Dependents □ Deletion of Dependents
□ Update/Change (i.e. Address, Birth, Name, Phone Correction)

IV. 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? ☐ Yes - Tobacco surcharge will apply ☐ No – Surcharge will NOT apply

B. If your spouse is selected for coverage; please answer the following question(s).

Spouse question #1: Is your spouse eligible for health benefits coverage through their employment?
☐ Yes – Please answer Spouse question # 2 ☐ No - Surcharge will NOT apply skip to part V

Spouse question #2: Is your spouse enrolled in health benefit coverage through their employment?
☐ Yes – Surcharge will NOT apply skip to part V ☐ No – Please answer Spouse Question #3

Spouse question #3: Is your spouse eligible for SHBP coverage through his or her employment?
☐ Yes – Surcharge will NOT apply ☐ No – Spousal Surcharge will apply

NOTE: Please see reverse side of form for details regarding removal of surcharge(s)

V. Coverage Tier - Choose one of the options below - Acronyms: Tobacco (Tob) – Spouse (Sp) – Surcharge (SC)

☐ 10 Employee ☐ 94 Employee + Child(ren) ☐ 90 Employee + Sp ☐ 96 Employee + Sp + Child(ren)
☐ 40 Employee + Tob SC ☐ 95 Employee + Child(ren) + Tob SC ☐ 91 Employee + Sp + Tob SC ☐ 97 Employee + Sp + Child(ren) + Tob SC
☐ 92 Employee + Sp + Sp SC ☐ 98 Employee + Sp + Child(ren) + Sp SC
☐ 93 Employee + Sp + Tob & Sp SC ☐ 99 Employee + Sp + Child(ren) + Tob & Sp SC

VI. OPTIONS – Choose one of the options below - Acronyms: HRA (Health Reimbursement Arrangement) HDHP (High Deductable Health Plan)
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

UNITED HealthCare
☐ 31 Definity (HRA)
☐ 08 HDHP
☐ 03 Choice HMO
☐ 58 PPO
☐ 23 Medicare Direct

KAISER (For current Kaiser Members Only)
☐ 07 HMO
☐ 27 Senior Advantage

VII. Dependents (Complete only if you have family coverage) See reverse side of this form for dependent eligibility requirements. Coverage for each dependent requires submission of additional documents and coverage will not be updated until documentation is received and approved.)

Use the abbreviations provided to show the relationship of each dependent.

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	Full name of spouse and eligible dependents to be covered			Relationship (Circle)		Sex (Circle)		Date of Birth MO/DA/CCYR	Social Security Number (If available) DO NOT HOLD FORM
	Last	First	Initial	SP	SC				
	_____			NC	LC	M	F	_____/_____/_____	☐☐☐-☐☐-☐☐☐☐
	Last	First	Initial	SP	SC				
	_____			NC	LC	M	F	_____/_____/_____	☐☐☐-☐☐-☐☐☐☐
	Last	First	Initial	SP	SC				
	_____			NC	LC	M	F	_____/_____/_____	☐☐☐-☐☐-☐☐☐☐
	Last	First	Initial	SP	SC				
	_____			NC	LC	M	F	_____/_____/_____	☐☐☐-☐☐-☐☐☐☐

VIII. 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 knowingly and willfully make false or fraudulent statement or representation to the Department regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature of Employee: _____ Date: _____

TERMS, CONDITIONS, AUTHORIZATION, AND INSTRUCTIONS

General Information:
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 . 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 premiums.

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

- To enroll in coverage
- Change Option or Tier
- Update Dependent Information
- Change Member Identification

You should read this side of the form and then complete Sections I, III, IV, V, VI, VIII, and section VII if adding, deleting or correcting dependents. Incomplete forms **will not** be returned for completion. Read the Attestation in Section VIII carefully, then sign and date the form. The effective date of coverage is dependent upon, the qualifying event date and/or your payroll deduction for coverage. Refunds can not be issued for late submission of Change requests or submission of incorrect or incomplete information. You will be bound to the coverage tier and Option selected and based on answers to the surcharge questions.

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 SHBP Summary Plan Document 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

Surcharge Questions:
Spousal Surcharge – will be added to your monthly premium if you elect to cover your spouse who 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 provided you answer the surcharge questions. If you fail to answer all of the applicable surcharge questions you will automatically be charged the surcharge 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. If you fail to answer the surcharge question you will automatically be charge the surcharge until the next Plan Year.

How to Remove Surcharge
See Instructions on the SHBP web site www.dch.georgia.gov located in the SHBP eligibility forms section.

The change in premiums will be effective based on the payroll deduction 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.

Eligible Dependents
Be sure to circle the proper code in Section VII to describe the dependent's relationship to you. The following describes the dependents that are eligible and the documentation requirements for each.
a) SP – Your legal Spouse as defined by Georgia law – Copy of certified marriage license or copy the most recent jointly filed Federal Tax Return with spouse's signature (financial information blacked out)
b) NC – Your Natural Child – Copy of Birth Certificate showing parents names. (Birth Card issued by hospital for New Born is accepted)
c) SC – Step Child – Copy of Birth Certificate showing spouse as parent AND a copy of certified marriage license for yourself and spouse AND a notarized statement that the SC resides in your home not less than 180 days each 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 a notarized statement that the 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, university, or institution for the training of nurses. A Student Status information form is located on the SHBP website www.dch.georgia.gov A completed Student Status form along with proof of Full Time Student Status documentation must be sent together to SHBP for review and processing.
Dependent children ages 19 through 25 who are employed in a benefit eligible position are not eligible for coverage regardless of student status.
NOTE: Dependents will not be verified as having coverage until documentation has been received and entered. Dependent children over the age of 19 must periodically update eligibility to continue coverage. Coverage for dependents who fail to update eligibility prior to termination of coverage will only be updated for the current plan year once documentation is received. No retro coverage beyond the current plan year will be given.

Penalties for Misrepresentation – If a SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filling for benefits, the SHBP may take adverse action against the participant, including but not limited 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 or her beneficiaries where not entitled). Penalties may include a lawsuit, which may result in payment of charges back 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 and your dependents will automatically lose SHBP coverage for 12 months beginning on the date that your false response is discovered.

Authorization: I have read and agree to abide by the Terms, Conditions, and Instructions provided on this form. I hereby authorize my employer to deduct each month from any wages due me the premium amount and any applicable surcharges 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 rehired 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 may not change Options 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 my employer to automatically transfer my coverage to the United HealthCare Definity (HRA) unless I make another coverage selection as allowed by the plan. I understand that if I fail to answer a questions concerning one of the surcharges, I will automatically be charged the applicable surcharge. Surcharges will apply until 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.