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

Please read the Terms, Conditions and Instructions prior to completing the form.

I. EMPLOYEE/MEMBER IDENTIFICATION SSN ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth ___/___/___ ☐ Male ☐ Female

Last Name ______________________ First ______________________ Middle Initial ________

Street Address ______________________________________ Apt/Box/Route ____________

City ____________________ State ________ Zip Code (9 digits) __________ Daytime Telephone Number (   ) ____/______
Area Code

II. Department Information only

Payroll Location No. ____________ Date you started working for the Department/School System ______________

Work Unit or School ______________________

III. Statement (check only one statement – Ineligible Employee or Declination)

☐ **Ineligible Employee – I understand that I am not eligible for coverage under SHBP because my job is: (check one)**

☐Part-Time ☐Seasonal ☐Intermittent ☐Temporary ☐For emergency period only

☐ **Declination by New Employee (check only one statement)**

☐ Decline SHBP coverage because of other health insurance coverage ☐Decline SHBP coverage because of other reasons

IV. Certification. I understand that if I decline coverage at this time, I cannot 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 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 $1000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make a 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. I also understand that, when I do enroll, my choices will be limited to the HRA and HDHP options only for the first Plan Year.

Employee Signature: ______________________________ Date: ______________

Note: Employees enrolled in the Plan transferring between school systems or departments or rehired within the same Plan Year (i.e., Jan 1 thru Dec 31) do not have the option of declining coverage during the Plan Year.

Terms and Conditions

General Information

- This form must be completed by a member/employee who discontinues coverage under the State Health Benefit Plan. Mark your Statement in Section III and read and sign acknowledging your understand the Certification in Section IV.
- Enrollment in the State Health Benefit Plan
- Enrollment in the State Health Benefit Plan 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 State Health Benefit Plan SPD for pertinent conditions
- Upon the loss of member's/employee's or dependents health benefit coverage through Medicaid, Medicare, the group or COBRA coverage of the spouse or former spouse, a member/employee has the opportunity to CHANGE tiers provided the request is made within 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, and the date of coverage termination.)
- Upon the acquisition of coverage under a spouse's group plan or your spouse's new employment you may CHANGE tiers to employee only coverage 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 other 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.
- Upon the loss of all eligible dependents, you may change coverage tier to employee only provided the request is filed no later than 31 days following the event.
- Retires may continue coverage at the time of retirement but are not allowed to enroll for coverage.

Open Enrollment Period

Open Enrollment is a time each year when active employees may enroll or **CHANGE** option or type of coverage, 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 15-day period beginning no earlier than October 15 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.