

TERMS, CONDITIONS, AUTHORIZATION, AND INSTRUCTIONS

Change and Miscellaneous Update Form

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 for the following reasons:

- Currently have SHBP coverage and experience a Qualifying Event
- Change of address and personal information

You should read this side of the form and then complete Sections I, III, IV, V, VI and Section VII if covering dependent(s). 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 hire date and your payroll deduction for coverage. Refunds can not be issued for incorrect or incomplete information. You will be bound to the coverage tier and Option selected and based on answers to surcharge questions.

Change of Coverage: 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 Documents which are posted at www.dch.georgia.gov. Coverage changes made outside the Open Enrollment Period will be effective the first day of the month following the appropriate payroll deduction. (Newborns may be covered from date of birth if appropriate deduction is taken and request of coverage is reported with 31 days of birth).

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 dependent(s) have used tobacco products in the previous 12 months.

How to Remove Surcharge: See Instructions on the SHBP Website www.dch.georgia.gov/shbp under the Active Employees column. 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 VI 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 of your 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 day 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 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 or 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 covered dependents who fail to update eligibility prior to termination of coverage will only have coverage 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 a change of coverage or when filling 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. Intentional misrepresentation in response to surcharge questions will have significant consequences. You and your covered dependent(s) 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 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 or cancel coverage until the next Open Enrollment Period except under limited conditions. I understand that if I terminate my employment and I 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 and 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 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 question(s) concerning one of the surcharges, I will automatically be charged the applicable surcharge. Surcharges will apply until the next plan year or until I complete the surcharge removal process. 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.

DOCUMENTATION FOR FAMILY INSURANCE COVERAGE

In order to cover dependents under State Health Benefit Plan for Family coverage, you must provide documentation of their relationship to you, along with your enrollment form. This information is also stated under Section VI on the front of the enrollment form.

Listed below is the documentation required. No dependent will be covered until this information is received and approved by State Health Benefit Plan. If information is not provided at the time you fill out the enrollment form for **Family** coverage, it will delay the start of the dependent's coverage.

Copies of certified documents must have the seal visible. You may need to rub over a raised seal on the original document with a pencil or chalk to show the seal on the copy.

Relationship	Required Document(s)
SP-Spouse	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.
NC-Natural Child or Student Child	Copy of certified birth certificate.
SC-Stepchild	1-Copy of certified birth certificate showing your spouse is the natural parent; AND 2-Copy of certified marriage license showing the natural parent is your spouse; AND 3-Notarized statement that the dependent lives in your home at least 180 days per year.
OT-Other child (which includes Adoptions and temporary and Permanent guardianship)	1-Copy of court decree showing your financial responsibility for the dependent; AND 2-Copy of certified birth certificate; AND 3-Notarized statement that dependent lives in your home on a permanent basis.