

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
State Health Benefit Plan
Retiree /Surviving Spouse Form

Mail to:
 State Health Benefit Plan
 P. O. Box 1990
 Atlanta, Georgia 30301-1990

I. 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 () _____

II. RETIREMENT SYSTEM USE ONLY

Retirement System No. _____ Retiree Number _____ Date of First Deduction ____/____/____

III. COVERAGE ACTION

Enrollment in Retirement System Last Payroll Deduction Date ____/____/____

Service Retirement Social Security # of Deceased _____ - _____ - _____

Disability Retirement Surviving Spouse/Dependent (Last Payroll Deduction Date not applicable)

Change of Coverage Option

Change of Coverage Tier (*) Date of Event ____/____/____

Check the box below that best describes the reason for this membership action and give the date of the event. These actions require supporting documentation:

Marriage Divorce Change in Employment Status Affecting Eligibility for Health Coverage

Acquisition of Dependent Death of Dependent

()When changing the coverage tier from Family to Single you cannot add your dependent(s) back unless you experience a Qualifying Event. The retirement of your spouse or the increase in his/her premium is NOT a Qualifying Event.*

Which Retirement System will provide benefits? _____

IV. COVERAGE OPTION (Check your choice of only ONE of the coverage options below):

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

Select Vendor: **CIGNA** **UNITEDHealthCare**

Select Option for individual(s) with Medicare Part B: Medicare Advantage Standard Medicare Advantage Premium

Select Option for family members not eligible for MA Options: HRA HDHP HMO OAP

V. COVERAGE TIER (Check your choice of the coverage tier): 10 Single 20 Family

VI. DEPENDENTS AND MEDICARE See reverse side of this form for dependent eligibility requirements. Coverage for all dependents requires submission of additional documents and coverage will not be updated until documentation is received and approved. "Not Entitled" for Medicare Part "A" means that neither you nor your spouse have contributed to Social Security or paid Medicare tax in order to make you eligible. Use the abbreviations provided to show the relationship of each dependent:

Relationship Codes -- SP for your wife or husband NC for your natural child SC for your stepchild LC for your Legal Child

Full name of persons to be covered Last First MI	Relationship (See above)	Sex (Circle)	Date of Birth			Social Security Number (REQUIRED)	Medicare	Effective Date	Medicare Number
			MO	DA	CCYR				
RETIREE (SAME AS ABOVE)	SELF						Part A <input type="checkbox"/> Yes <input type="checkbox"/> No		
							Part B <input type="checkbox"/> Yes <input type="checkbox"/> No		
							Part D <input type="checkbox"/> Yes <input type="checkbox"/> No		
		M F					Part A <input type="checkbox"/> Yes <input type="checkbox"/> No		
							Part B <input type="checkbox"/> Yes <input type="checkbox"/> No		
							Part D <input type="checkbox"/> Yes <input type="checkbox"/> No		
		M F					Part A <input type="checkbox"/> Yes <input type="checkbox"/> No		
							Part B <input type="checkbox"/> Yes <input type="checkbox"/> No		
							Part D <input type="checkbox"/> Yes <input type="checkbox"/> No		

VII. ATTESTATION: I have read and agree to abide by the Terms, Conditions and Instructions provided on the back of this form. I understand that my eligibility for the State Health Benefit Plan is contingent on continuous coverage. I agree to pay directly for any lapse of coverage caused by administrative delay. If I have selected an Option that ceases operation, I authorize the State Health Benefit Plan to automatically transfer my coverage to the default option, unless I make another coverage selection as allowed by the Plan. I do hereby attest that the above information is true and correct to the best of my knowledge. I understand that if I misrepresent eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against me, including but not limited to terminating coverage (for the member and his/her dependent(s) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the member or his or 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.

Signature of Employee: _____ Date: _____

Terms, Conditions and Instructions

Retiree/Surviving Spouse Form

General Information: This form must be used by a retired or retiring State Health Benefit Plan (SHBP) member, or surviving spouse/dependent(s), who will be receiving an annuity from one of the following retirement systems: Teachers' Retirement System (TRS), Employees' Retirement System (ERS) or Public School Employees' Retirement System (PSERS), Legislative Retirement System, Superior Court or District Attorneys' Retirement System or any local school system's retirement system. The annuity must be a sufficient amount to pay the premium deduction for health benefit coverage. Effective date of the change is dependent on payroll deadlines and information provided. Refunds will not be issued for late submission or incorrect information. You must apply for continued coverage for yourself and covered dependents within 60 days of the date your active coverage ends. Members initially retiring in TRS, ERS and PSERS do not need to complete this form to continue their coverage into retirement as it is automatically moved to retiree coverage. Members will receive a letter from SHBP advising of this change and give them the opportunity to change elections or discontinue coverage.

Use this form for the following reasons:

- Qualifying Events
- Change of address and other information
- Transfer from active to retiree health coverage (not required for retirement in TRS, ERS or PSERS)

Review the instructions and complete sections I, III, IV, V and Section VI if covering dependent(s). Incomplete forms **will not** be returned for completion. Please read the Attestation in Section VII carefully, then sign and date the form.

Enrollment for Coverage: Coverage for a retired employee, teacher or surviving spouse/dependents must be continuous. If the annuity payment from your retirement system does not begin immediately, your coverage will be interrupted. To protect your eligibility for coverage, the SHBP eligibility office should be contacted at (404) 656-6322 or (800) 610-1863 for instructions concerning alternative payment provisions allowed by the Plan.

The surviving spouse married to member more than one year may elect to continue coverage for themselves and eligible surviving dependent children. No additional dependents may be added to the coverage (No Exceptions). Dependent children may continue coverage under the surviving spouse contract until they no longer meet the eligibility requirements (See Eligible Dependents). The surviving spouse married to member less than one year is eligible for 36 months under COBRA provisions.

A surviving spouse who is also eligible for coverage under the Plan as a retiree or employee may elect coverage as a surviving spouse or employee. Such persons cannot elect double or dual coverage under these separate provisions of the Plan. The surviving spouse may resume coverage upon termination of employment if otherwise ineligible for coverage as a retiree.

Surviving dependent children who are receiving an annuity from the retirement system may continue coverage until they no longer meet the eligibility requirements (See Eligible Dependents). Surviving dependent children not receiving an annuity from the retirement system are eligible for 36 months under COBRA provisions.

Eligible Dependents: Be sure to use 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 dependent **IF** added through a qualifying event.

- 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 which includes adoptions – Copy of Birth Certificate showing parents names. (Birth Card issued by hospital for newborn is accepted). A copy of the adoption agreement is required for adoptions.
- 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 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 and, if employed, not eligible for health coverage from their employer. A Student Status Information form is located on the SHBP Website www.dch.georgia.gov/shbp. 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 from the date of the qualifying event or the current plan year, whichever is later, once documentation is received. No retroactive coverage beyond the current plan year will be given.

Retirees who return to state employment in a benefits-eligible position must discontinue retiree coverage and elect coverage as an employee. When active employment ends, the retiree **MUST** notify SHBP within 60 days to resume coverage as a retiree and premiums will be deducted from his/her annuity.

Eligibility to Change Coverage: Covered retirees and surviving spouses/dependents may change to any available option during the annual Retiree Option Change Period. However, retirees and surviving spouses/dependents **cannot** enroll for health coverage during this period.

Change of Option: At the time of enrollment as a retiree or upon reaching age 65 and electing Medicare, or if the annuity is not sufficient to cover the premiums, a change may be made to any available option.

Change of Tier or drop SHBP Coverage: A change to Single Tier or discontinuation is allowed at anytime. **However, if you drop the coverage, you may never get it back unless you return to work in a SHBP benefits eligible position.**

Qualifying Events: Retirees are allowed to increase coverage tiers to cover a newly acquired dependent only in limited circumstances; i.e. marriage, birth of a child, adoption of a child and receipt of a qualified medical child support order (QMCSO) provided the request is filed no later than 31 days following the event. Coverage changes made outside the annual Retiree Option Change 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).

Medicare Information – Age 65 or when eligible due to Disability: Premiums and benefits payments are based on the parts of Medicare a retiree and/or covered dependents select (A, B, and D); therefore, accurate Medicare information must be provided by the member. If you or any of your covered dependents (1) have enrolled in Medicare, check Yes in section VI and provide all of the information requested and attach a copy of the Medicare card(s) or (2) are not eligible to receive Medicare benefits at the time of your retirement because of your/their age, check No in section VI. If you or covered dependent enroll in Medicare you **MUST** send SHBP a copy of your Medicare enrollment card. SHBP will report discount to retirement system on the next electronic file.