



Enroll/Decline *INFORMATION ONLY*
Health Insurance 2022 Plan Year

Name: _____

BirthDate: _____ SSN: _____

Are you a Transfer* from another Georgia School System? Yes NO

If Yes: Transferring from what system? _____

Note: Transfers must remain in the same medical plan until the next open enrollment

I ELECT THE FOLLOWING MEDICAL PLAN (INITIAL BY THE PLAN):

HRA BCBS GOLD _____ BCBS SILVER _____ BCBS BRONZE _____

HMO BCBS HMO _____ UHC HMO _____ Kasier HMO _____

HDHP UHC HDHP _____ **DECLINE ALL** MEDICAL _____

I (or any covered family member) HAVE USED Tobacco in the last 60 days. Additional \$80 Surcharge for Yes. (*initial by the selection*)

NO Tobacco Use _____ Yes Tobacco Use _____

To add family members to Health Insurance, list them below.

Note: ADP/SHBP will request a copy of your marriage certificate (spouse), birth certificates (children) and copies of social security cards for your covered dependents. You will need to send these documents to ADP/SHBP when requested.

Name	Birthday	SSN	M/F	Relationship

Signature: _____ **Date:** _____