Please type or print clearly in ink

Georgia Department Of Community Health
State Health Benefit Plan

P.O. Box 1990
Atlanta, Georgia 30301

Request to Continue Health Benefits During Leave of Absence Without Pay

I. Member and Payroll Identification.

Provide all requested information.

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Last Name | First | Initial

Apartment/Box/Route

Street Address

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

County of Residence | Daytime Telephone Number ( ) Area Code

Is this form a new application or a change to a previously approved application? (Check One) ☐ New ☐ Change ☐ Extension

Department or School System

Work Unit or School

Payroll Unit Person to Contact for Information

Payroll Unit Telephone Number

State Health Benefit Plan Payroll Location Number

II. Leave Type and Payment Information.

Check leave type. Provide information requested for the leave type and payment amount.

☐ **(01) Disability/Illness -** Attach Form SHBP 66-005 from physician describing disability/illness and periods of disability from normal job duties **IS CONDITION RELATED TO PATIENT'S EMPLOYMENT?** ☐ **YES** ☐ **NO**

☐ **(02) Educational -** Actual period of instructions: **FROM:** _____ **TO:** _____

☐ **(03) Emergency Military -** Attach copy of orders.

☐ **(04) Suspension -** Attach letter from employer stating period of suspension.

☐ **(05) Family Leave -** (Check One)
- ☐ **Birth/Adoption** (Attach copy of letter or form approving family leave.)
- ☐ **Illness** (Attach copy of letter or form approving family leave and Form SHBP 66-005 or equivalent.)
- **Military -** ☐ **Care Giver**
- **Military -** ☐ **Called to Duty**

Period of approved family leave is: **FROM:** _____ **TO:** _____

☐ **(06) Employee's Convenience -** Will you be employed by another part or self-employed during leave? ☐ **YES** ☐ **NO**

☐ **(08) Employer's Convenience -** Attach letter from Employer From: _____ To: _____

PAYMENT INFORMATION

$ _____

You will be billed monthly - all premium payments are due by the 26th of the month prior to coverage.

III. Member Certification.

Read this section carefully. Sign and date where requested.

- I understand that health benefits may be terminated if payment is not received by the 26th of the month. I also understand that health benefits will terminate at the end of the approved leave of absence without pay or at the expiration of the time allowed by the State Health Benefit Plan unless payroll deductions are resumed.
- **I understand that application for coverage while on leave without pay must be signed within thirty-one (31) days and filed with the State Health Benefit Plan within sixty (60) days after termination of paid coverage through payroll deductions.**
- I request to continue coverage of health benefits during the period of leave of absence without pay, and I certify that all statements on this application and any attachments are correct to the best of my knowledge and belief. I further certify that I have read and agree to adhere to the conditions on the reverse side of this application. I do herby 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.

X _____ Member Signature

_____ Date

IV. Agency Certification.

Provide current coverage and leave without pay information. Sign and date where requested.

Option | Coverage

Leave Without Pay is Authorized Beginning On			Authorized Leave Ends On			Anticipated Last Payroll Deduction		
Month	Day	Year	Month	Day	Year	Month	Day	Year

The above named employee will be granted a leave of absence of the type indicated for the period shown at left.

X _____ Signature of Authorizing Official

_____ Title _____ Date

SHBP 66-003 (Rev.02/08)

TERMS, CONDITIONS, AND INSTRUCTIONS

General Information

This form should be used to apply for continued health benefit coverage under the State Health Benefit Plan (SHBP) during a period of leave of absence without pay. The continued coverage will be governed by the **Leave Types and Time Limits** listed below, and shall be for the same coverage option and coverage type for which the employee is enrolled at the time the leave without pay commences (unless the employee qualifies for an option or coverage change under SHBP provisions). Health benefits may be continued for the period of leave, as approved by the SHBP, subject to the **Conditions and Documentation** requirements listed below. Premium payments for this continuation of coverage will be made directly to the SHBP.

Leave Types and Time Limits

Time limits for continued health benefit coverage during a period of leave of absence are considered to run concurrently. When an employee qualifies for continued coverage under multiple leave types, the total period of continuation may not exceed twelve (12) calendar months. See Family Leave for an exception

Disability leave of absence shall be for the period of the employee's disability due to illness, accident or disability, as certified by a licensed physician, not to exceed twelve (12) consecutive calendar months.

Educational leave of absence shall be for the period of educational leave not to exceed twelve (12) consecutive calendar months.

Emergency Military leave of absence shall be for the period during which an employee is ordered to military duty (not to exceed twelve (12) consecutive calendar months.)

Suspension leave of absence shall be for the period of the suspension, not to exceed twelve (12) consecutive calendar months.

Family leave of absence shall be for the period during which the employee is absent from work to care for the employee's child after birth or placement for adoption; the employee's seriously ill spouse, child, or parent; or when the employee is absent from work due to the employee's serious health condition or when an employee's spouse, son, daughter, or parent is called to active duty. The period during which coverage may be continued shall not exceed twelve (12) weeks in any (12) month period. Exception: An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered servicemember who is being a Care Giver to a recuperating servicemember due to an injury is entitled to (26) weeks in any (12) month period.

Employee's Convenience leave of absence shall be for the period of approved leave for the employee's convenience, not to exceed twelve (12) consecutive calendar months.

Conditions and Documentation

Withdrawal of employee contributions from a retirement system shall constitute resignation and approval of continued coverage during a period of leave without pay shall be terminated. The employee's eligibility for further coverage will then be governed by the extended beneficiary provisions of the plan. Documentation must be given to employer.

Disability leave: The period of disability must be certified by a licensed physician using Form SHBP 66-005. The SHBP may require additional information from the certifying physician, or may require review by another licensed physician, if the disability period is longer than the norm for the diagnosis.

Educational leave: The employee must certify the period of absence on Form SHBP 66-003. The absence may be only for the period of instruction.

Military leave: A copy of the appropriate orders must be provided.

Suspension leave: A letter stating the period of suspension, signed by the appropriate organizational official, must be provided.

Family leave: For family leave due to birth or adoption: A copy of the employer's letter or form approving the period of leave must be provided. At minimum, the form or letter must show the period of approved leave, the reason for the leave, and the date of birth or placement for adoption. For family leave due to illness of the employee or an eligible family member: A copy of the employer's letter or form approving the period of leave must be provided. Form SHBP 66-005 or a copy of the employer's physician certification form providing information equivalent to Form SHBP 66-005 must also be provided. Military: Copy of orders and disability letter from physician.

Employee's Convenience leave: The employee may not continue health benefits under the SHBP if self-employed or employed by another party during the period of leave.

Employer's Convenience leave a letter from employer stating the period of leave.

Premium Information

Premiums shall be payable monthly during the period of approved leave of absence without pay. Rates shall be subject to change upon notice at the beginning of any month during the leave period. Checks for premium payment should be made payable to "State Health Benefit Plan." Contact your personnel/payroll office or the State Health Plan Benefit for rates (which may include a processing fee).

Extensions and Continuations

An extension of leave may be requested if the employee is unable to return to work at the expiration of the approved leave and the maximum period has not been exhausted. The extension request must be signed by the employee and certified by the employing entity no later than thirty one (31) days following expiration of coverage under the approved leave of absence. The attending physician must complete the disability certification if the leave is due to disability, and the extension request must be filed with the SHBP within sixty (60) days following the expiration of coverage under the approved leave of absence.

Recurrent period of leave of absence without pay for the same or related illness shall be considered one approved leave period unless the employee returns to work and has coverage through payroll deductions for a period of three (3) consecutive calendar months.

Penalties

Failure to provide accurate information or failure to submit the appropriate premium payment(s) in a timely manner shall be cause for termination of coverage until such time as the member returns to active pay status. Failure to submit the premium payment(s) by the first of the month in which coverage is effective shall be cause for the SHBP to charge a late fee. Submission of a check that is not honored by the institution on which drawn shall be cause for SHBP to charge a processing fee or terminate coverage until the employee returns to active pay status.