State Health Benefit Plan Individual's Late Enrollment Penalty (LEP) Authorization Form (Payment of the Medicare Part B Premium Surcharge) for One Person

In order for the State of Georgia, Department of Community Health, State Health Benefit Plan (SHBP) to pay the late enrollment premium surcharge portion of my Medicare Part B premium to the Centers for Medicare and Medicaid Services (CMS), on my behalf, I request that CMS send notice of the premium surcharge amount due to the State of Georgia, State Health Benefit Plan, P.O. Box 1990, Atlanta, GA 30301-1990.

I authorize CMS to furnish the State of Georgia, Department of Community Health, State Health Benefit Plan information from time to time as may be necessary to administer the premium surcharge payment arrangement.

I also understand that, although the State of Georgia, Department of Community Health, State Health Benefit Plan is paying the premium surcharge portion of my Medicare Part B premium, I am still responsible for paying the monthly Part B premium payment. I understand that CMS will continue to collect the monthly premium either through benefit withholding or, where there is no benefit, direct remittance.

I also understand that after signing and completing this form, it should be mailed to the State Health Benefit Plan, P.O. Box 38342, Atlanta, GA 30334 in the enclosed green envelope.

_____ _____

Print First and Last Name as shown on your insurance card | Date

_____ _____

Signature | Your Medicare Number (please print # legibly)

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(Please print the name of the SHBP retiree if you are covered as a dependent)