ALL EMPLOYEES MUST COMPLETE THIS FORM AND SEND IT TO HUMAN RESOURCES

Name (Last, First, MI)		SSN:
Home Address:	City:	State: Zip:
Work Location:	Date of Birth	

Certification for NON-TOBACCO User

I am applying for the discounted non-tobacco user contribution for non-tobacco using members participating in the SMITHAMUNDSEN Medical Plan. I understand that to be eligible for the non-tobacco user contribution rate, neither I nor any of my eligible covered adult dependents may use any nicotine or tobacco products including, but not limited to, cigarettes, cigars, snuff, chewing tobacco, pipes, etc.

I hereby attest and agree that neither I nor my covered spouse use nicotine or tobacco products. I agree to notify the Human Resources department promptly at any time that I or any of my eligible, covered dependents begin using nicotine or tobacco products and understand that such use will cause the eligibility for the discounted non-smoker contribution rate to be voided.

I further understand that knowingly falsifying this form constitutes fraud against the health plan and may result in owing back contributions at the non-discounted tobacco user contribution rates, loss of health coverage, disciplinary action and/or termination of employment.

By signing in the space provided below, I acknowledge and attest that neither I nor my covered spouse use nicotine or tobacco products. Additionally, I understand that it is my responsibility to inform Human Resources promptly at any time that I or any of my eligible, covered dependents begin or stop using nicotine or tobacco products.

Employee Signature: ____Date:_________________

Certification of TOBACCO User

By signing in the space provided below, I acknowledge and attest that myself or my covered dependents use nicotine or tobacco products. I agree to assume the Tobacco User surcharge fee ($60.00/mo) until all participating individuals are no longer tobacco users. Additionally, I understand that it is my responsibility to inform Human Resources promptly at any time that I or any of my eligible, covered dependents begin or stop using nicotine or tobacco products.

Employee Signature: ____Date:_________________