Employee Name: _____ Employee ID: _____

Tobacco-Free Discount Benefit Affidavit

As an SMHCS employee enrolled in our medical plan, you may be eligible to receive a $10 per pay-period discount on medical premiums if you do not smoke or use tobacco products. Tobacco products include cigarettes, cigars, snuff, chewing or pipe tobacco, electric cigarettes, or any other tobacco product, regardless of the frequency or method of use.

Please review this affidavit carefully, answer the questions below, and sign this form. This affidavit must be completed and returned by August 31 in any given year, in order to qualify for the discount for the following plan year. Once signed, this form will carry over into each new plan year. ***However, if you have not signed a form since June of 2014, please complete and send again.***

Those employees who do smoke or use tobacco products may also be eligible to receive the reward if they complete an SMHCS approved smoking cessation program through EAP, even if the program proves unsuccessful. If you smoke or use tobacco products and would like to quit, we encourage you to enroll in a smoking cessation program. To learn more about the programs available to help you stop using tobacco products, please contact EAP at 917-1240.

The information you provide on this form will be kept confidential and will not be used for any purpose other than to determine your eligibility for the discount and for participation in any wellness incentive programs that may be applicable for the benefit year.

☐ **I am <u>not</u> a smoker or tobacco user.**

☐ **I am a smoker or tobacco user.**

If you state that you do not use tobacco products, you must remain tobacco free until September 30 of each plan year, in order to continue receiving the discount. If you begin to use tobacco products, you must immediately notify Human Resources in writing by completing the "Tobacco-Free Status Change Form," and you will therefore forfeit your premium discount for the remainder of the plan year.

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, please contact the Human Resources at extension 6177 and we will work with you to develop another way to qualify for the reward. For example, you may still qualify for the reward by having your physician complete the Wellness Alternate Standard Certification form, available through the HR Home Page on Pulse, which verifies that a medical condition makes it too difficult, or medically inadvisable for you to be tobacco free at this time, and submit that form to Human Resources.

By signing this, I certify that the above information is true and correct. I also certify that if I am currently not a smoker or tobacco user, and this status changes during this plan year, I will immediately notify Human Resources of such change. I understand that I will be subject to random nicotine testing through out the year. I further understand that providing false information may subject me to repay the discount I received, pay back benefits received for claims paid, and may also subject me to discipline, up to and including termination of employment.

Signed: _____ Dated: _____

Return completed form to Human Resources
Fax #941-917-4889