Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ B#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SMOKING AND TOBACCO USE AFFIDAVIT**

This form is used to determine your medical insurance rate. You are eligible for the non-smoker/non-tobacco discount if you certify that neither you nor your spouse/partner have smoked or used tobacco and/or unregulated nicotine products as noted below within the last 90-days.

|  |  |  |
| --- | --- | --- |
|  | Tobacco and/or Unregulated Nicotine Products Used Within the Last 90 Days? | |
| Relationship | Yes | No |
| Employee |  |  |
| Spouse/Partner |  |  |

Note: Use of tobacco and/or unregulated nicotine products include:

* Smoking (tobacco and/or tobacco-free products, that might be smoked via cigarettes, pipes, water pipes, and/or hookahs)
* Smokeless tobacco (including snuff, snus, and chew)
* Vaping and/or other use of unregulated nicotine products (such as electronic cigarettes)

If you (and your spouse/partner) complete an approved tobacco cessation program or become

Tobacco /nicotine free for 90 days at any time during the year, you may resubmit the affidavit to be considered for the discount premium. If you (and your spouse/partner) start to use tobacco/ nicotine based products while receiving this discount premium, you must immediately notify Human Resources to change your payroll deduction status.

A reasonable alternative option will be made available if you (and your spouse/partner) are unable to, or if it is medically inadvisable to, meet the requirements of this program. Please contact the Human Resource Department to discuss your options.

By signing this form I certify that:

1. I have truthfully checked the YES or NO boxes that accurately reflect mine and my spouse/partner’s use of tobacco and/or unregulated nicotine products.
2. I understand that if I currently use tobacco and/or unregulated nicotine products and stop using them in the future, I will be eligible for the lower medical insurance rate the month following Berea College’s receipt of a new SMOKING AND TOBACCO USE AFFIDAVIT certifying that I have not used tobacco and/or unregulated nicotine products. During the prior 90 days.
3. I understand that it is my obligation and responsibility to notify Human Resources if I and/or my spouse/partner covered under the plan begin to use tobacco and/or unregulated nicotine products at any further date.
4. I understand that if I fail to complete this Affidavit truthfully, Berea College may adjust my medical insurance rate retroactively. Upon written notification, I must reimburse Berea College any amounts reduced from my medical insurance rate for the period for which I falsely certified eligibility for the reduced rate.
5. I understand that if I state on this form that I do not use tobacco and/or unregulated nicotine products, I may be asked at a later date to supply a certification from my healthcare provider.
6. LEASE NOTE: If you do not check either box nor submit this form, you will not be eligible for the d

***I hereby certify that the above information is true to the best of my knowledge and understand my responsibilities in regards to informing Human Resources regarding a change in my status.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Employee Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Spouse/Partner Signature