



**Group Insurance Benefits
Certification Regarding Tobacco Use**

EMPLOYEE NAME (PLEASE PRINT):		DEPARTMENT:
NON-TOBACCO-USER PREMIUM	<input type="checkbox"/> I certify that I am eligible for the Non-Tobacco-User Premium by checking this box and returning this form to Human Resources. By checking this box, I certify the truth and understanding of the following: <ul style="list-style-type: none"> ❖ I certify that all persons covered by my health insurance through Botetourt County (including myself, my spouse and any other dependents) are not currently using, and have not used, any tobacco products in any form (cigarettes, cigars, pipes, herbal tobacco products, chewing tobacco, dip, snuff, electronic nicotine delivery systems, etc.) within the last 6 months. ❖ I certify that if this information changes at any time in the future, while I have health insurance coverage through Botetourt County, I will notify Botetourt County Human Resources of such change within 30 days through completion and re-submission of this form. ❖ I certify that this information is true and correct to the best of my knowledge. ❖ I understand that if it is determined that I (or my covered spouse or any of my covered dependents) have used tobacco products within the last 6 months or if I (or my covered spouse or any of my covered dependents) start using tobacco products after the date of this certification without notifying Botetourt County Human Resources, I will be subject to penalties including, but not limited to, denial or retroactive termination of benefit coverage, payment of the premium difference since last certification, and disciplinary action including, but not limited to, termination of my employment. ❖ I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid. 	
	TOBACCO-USER PREMIUM	<input type="checkbox"/> I acknowledge that I will pay the Tobacco-User Premium by checking this box . I declare that one or more persons covered by my health insurance through Botetourt County uses tobacco products in some form or that I choose not to disclose my status as it relates to tobacco use. I understand that by checking this box I will pay the Tobacco-User Premium.

EMPLOYEE SIGNATURE _____

DATE _____