



## Certification Regarding Tobacco or E-cigarette Use

Check the appropriate box, sign and return to S.C. PEBA, 202 Arbor Lake Drive, Columbia, SC 29223.

Subscriber name: \_\_\_\_\_

Subscriber BIN/SSN: \_\_\_\_\_

### Non-tobacco or e-cigarette user

- ☐ I certify I am eligible for the non-tobacco-use premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:
- I certify all persons covered on my health insurance coverage through PEBA (including myself and any dependents) are not currently using, and have not used, any tobacco products or electronic cigarettes in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last six months.
  - I certify if this information changes at any time in the future while I have health insurance coverage through PEBA, I will notify PEBA of such change within 31 days through completion and resubmission of this form.
  - I certify this information is true and correct to the best of my knowledge.
  - I understand if it is determined that I (or any of my covered dependents) have used tobacco products or electronic cigarettes within the last six months or if I (or any of my covered dependents) start using tobacco products or electronic cigarettes subsequent to the date of this certification without notifying PEBA, I will be subject to penalties including, but not limited to, payment of premium difference since last certification plus a 10% penalty and elimination of the user's out-of-pocket maximum for current year and subsequent year.
  - I understand 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-use premium I have already paid.
- ☐ I certify I am eligible for the non-tobacco-use premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:
- I certify all covered individuals who use tobacco or electronic cigarettes have completed the State Health Plan's tobacco cessation program.
  - I certify this information is true and correct to the best of my knowledge.
  - I understand 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-use premium I have already paid.

### Tobacco or e-cigarette user

- ☐ I acknowledge I will pay the tobacco-use premium by checking this box. I declare that one or more persons covered on my health insurance coverage through PEBA uses tobacco products or electronic cigarettes in some form or that I choose not to disclose my status as it relates to tobacco or e-cigarette use. I understand that by not making an election I am choosing to pay the tobacco-use premium. Do not send me this certification again unless upon request.

Subscriber signature: \_\_\_\_\_

Date: \_\_\_\_\_

Benefits administrator signature: \_\_\_\_\_

Date: \_\_\_\_\_

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