FSD145

Freeport School District

FREEPORT SCHOOL DISTRICT
GROUP HEALTH CARE PLAN
TOBACCO (NICOTINE) USE SURCHARGE
Effective July 1, 2017

Beginning with the Health Care Plan Year (July 1, 2014), the Freeport School District Health Care Plan will implement a tobacco (nicotine) use surcharge. If an employee or any of their covered dependents have used tobacco within past 30 days, they will be required to pay an additional surcharge of $100.00 per month per person.

The Tobacco Use Affidavit Employee Form must be completed and returned to the Central Business Office, Attention Bernadette Mekalska, no later than July 31, 2017 in order to have the tobacco surcharge waived.

The tobacco surcharge will apply (to employee and any covered dependents) if the employee does not request a waiver by returning the Tobacco Use Affidavit Employee Form.

Tobacco (nicotine) products include but are not limited to: cigarettes, cigars, cigarillos, pipes, chewing tobacco, snuff, dip, and loose tobacco smoked via pipe or hand rolled cigarettes, and any other products containing nicotine.

The tobacco (nicotine) surcharge will apply until the following year. At the end of the year, you will again be asked about tobacco (nicotine) use. If tobacco use has been discontinued at least 30 days before the start of the next plan year, the employee may indicate so on the Tobacco Use Affidavit and the surcharge will be discontinued for the following plan year. Medical testing may be required to verify non-usage at the time of the request to drop the surcharge.

PLEASE COMPLETE THE TOBACCO USE AFFIDAVIT EMPLOYEE FORM AND RETURN TO THE CENTRAL BUSINESS OFFICE, ATTENTION BERNADETTE MEKALSKA, BY July 31, 2017.

FREEPORT SCHOOL DISTRICT HEALTH CARE PLAN
TOBACCO USE AFFIDAVIT

This form is used to determine your participation in the Freeport School District Health Care Plan Tobacco (Nicotine) Use Premium Surcharge. All employees must certify if they or any of their covered dependents are regular users of tobacco (nicotine) products or not. Tobacco (nicotine) products include but are not limited to: cigarettes, cigars, cigarillos, pipes, chewing tobacco, snuff, dip, and loose tobacco smoked via pipe or hand rolled cigarettes or any products containing nicotine. The Tobacco surcharge is $100.00 per month per person covered under the plan who uses tobacco or nicotine products (the surcharge amount will be adjusted for 9 month employees.)

Employee Name: _____

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Please list yourself and each person you cover under the Health Plan.

Has tobacco or nicotine products been used within the past 30 days?	**Indicate Yes or No for each individual**
	o Yes o No
	o Yes o No
	o Yes o No
	o Yes o No
	o Yes o No
	o Yes o No
	o Yes o No
	o Yes o No
	o Yes o No

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By signing this form, you certify the following:

1. I have truthfully checked the statement above that accurately reflects the use of tobacco products by myself or my covered dependents.

2. I understand that tobacco products include cigarettes, cigars, chewing or pipe tobacco, or any other tobacco or nicotine products regardless of the method of use.

3. I understand that I will be charged the Tobacco Surcharge if I do not complete and return this form to the Central Business Office, Attention Bernadette Mekalska, by the open enrollment deadline.

4. I understand that I am responsible for notifying the Plan at the Central Business Office, (Attention Bernadette Mekalska) immediately if I or any of my covered dependents begin using tobacco or nicotine products at any time throughout the year so that I can begin paying the surcharge.

5. I understand that I will be responsible for the surcharge until open enrollment of the following year. If at the following year open enrollment, I or any of my covered dependents are no longer using tobacco or nicotine products, I will complete a new Tobacco (Nicotine) Use Affidavit and will no longer be required to pay the surcharge. I also understand that laboratory testing or verification may be required to verify my and/or my dependents non-tobacco use status.

6. I certify that my statements on this form are true and accurate. I understand that any misrepresentation of information on this Affidavit will subject me to the requirement to pay the tobacco surcharge, through payroll deductions or otherwise, for the current plan year. ***I further understand that dishonesty or misrepresentation of information of this Affidavit may subject me to disciplinary action up to and including termination.***

Employee Signature: _____ Date: _____