MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
Tobacco Use Attestation Form

All sections of the form below must be completed in order for the form to be processed. Please print in blue or black ink.

LAST NAME: FIRST NAME: MI:		SOCIAL SECURITY NUMBER:	
HOME ADDRESS:	CITY:	STATE:	ZIP:
PERSONAL TELEPHONE NUMBER:	PERSONAL EMAIL ADDRESS:		

- **Please initial the appropriate box below to indicate whether or not you use tobacco on a regular basis.**
- **If you are a regular user of tobacco, please indicate whether you agree or decline to participate in the Plan's sponsored tobacco cessation program by checking the appropriate box.**

NON-TOBACCO USER

☐ I attest that I have not regularly used a tobacco product in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last three months. I attest that if this information changes at any time in the future, while I have health insurance coverage through the Mississippi State and School Employees' Health Insurance Plan (Plan), I will complete and submit a new attestation form within thirty days.

I certify that all information provided by me on this form is complete and accurate. I understand that any misrepresentation by me may result in the Tobacco Use Premium Surcharge being retroactively applied and/or cancellation of my coverage under the Plan.

______________________________ ______________

Signature Date

TOBACCO USER

☐ I acknowledge that I regularly used a tobacco product in some form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last three months and therefore, am subject to the Tobacco Use Premium Surcharge. I understand that should I cease using tobacco on a regular basis for at least three consecutive months, I will have the opportunity to submit a new attestation form and no longer be subject to the surcharge.

☐ **I agree to participate** in the Plan's sponsored tobacco cessation program. I understand that the $50 monthly Tobacco Use Premium Surcharge will be waived for an initial six months pending my completion of the program. I am also aware that I will only be able to participate in the Plan's sponsored program once every twelve calendar months. Call ActiveHealth Management at (866) 939.4721 to enroll.

☐ **I decline to participate** in the Plan's sponsored tobacco cessation program and understand that I will be charged the $50 monthly Tobacco Use Premium Surcharge.

I certify that all information provided by me on this form is complete and accurate.

______________________________ ______________

Signature Date

Form Submission:

- If you are an active employee, please return your form to your employer's Human Resources Department.
- If you are a non-Medicare retiree or COBRA participant, please mail or fax your form to:

Blue Cross & Blue Shield of Mississippi
P.O. Box 23734
Jackson, MS 39225-3734
Fax: (601) 664-5342

For more information visit KnowYourBenefits.dfa.ms.gov