STATE EMPLOYEES' HEALTH INSURANCE PLAN
ANNUAL TOBACCO USER PREMIUM DISCOUNT APPLICATION

Applicant Name	Contract Number

Declaration

This form may be used for two separate reasons. First, if you or your spouse are currently a tobacco user and are requesting to be approved for the Annual Tobacco User Premium Discount, you may use this form. Second, if you or your spouse have previously been a non-tobacco user and have been receiving the Non-Tobacco User Discount, you may fill out this form to notify the SEIB that you have used tobacco products within the last 12 months. Please check all appropriate boxes below:

CONTRACT HOLDER/MEMBER

☐ I have used tobacco products within the last 12 months. In order to be considered for the Annual Tobacco User Premium Discount, you must mark the box below:

☐ I have completed the 1-800-QUITNOW Program, a free program available to SEIB members, or an SEIB approved tobacco cessation program (verification must be attached).

SPOUSE

☐ My spouse has used tobacco products within the last 12 months and is covered as a dependent under the SEHIP. In order for your spouse to be considered for the Annual Tobacco User Premium Discount, you must mark the box below:

☐ My spouse has completed the 1-800-QUITNOW Program, a free program available to SEIB members, or an SEIB approved tobacco cessation program (verification must be attached).

I understand that if my application is approved my tobacco user premium discount will expire after 12 months, and I will be required to reapply for the premium discount. I also understand that if it is determined that I have provided false or misleading information in order to receive the tobacco user premium discount, I will be subject to disciplinary action and will be required to repay all discounts as well as all claims and other expenses incurred by the SEHIP, plus interest.

Signed: _____ _____ _____
Contract Holder | Date | Daytime Phone Number

Authorization

By signing below, I/we hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, any government agency or other organization or person that has any records or knowledge of my/our health to provide to the State Employees' Insurance Board any information related to my/our use of tobacco products.

Signed: _____ _____
Contract Holder | Date

_____ _____
Primary Care Physician | Primary Care Physician Telephone Number

Signed: _____ _____
Spouse (if covered under SEHIP) | Date

_____ _____
Primary Care Physician | Primary Care Physician Telephone Number

Return to: **State Employees' Insurance Board**
Wellness Department
Post Office Box 304900
Montgomery, AL 36130-4900

Toll-free: 866-838-3059
Montgomery: 334-263-8431
Fax: 334-517-9980