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

Name of Contract Holder	Contract Number

Declaration

Check the appropriate box below:

☐ I have used tobacco products within the last 12 months.

☐ My spouse has used tobacco products within the last 12 months and is covered as a dependent under the SEHIP.

☐ I have completed an SEIB approved tobacco cessation program (verification attached).

☐ My spouse has completed an SEIB approved tobacco cessation program (verification attached).

☐ I cannot stop using tobacco products as advised by my physician because it is unreasonably difficult due to a medical condition (statement from physician attached).

☐ My spouse cannot stop using tobacco products as advised by his or her physician because it is unreasonably difficult due to a medical condition (statement from physician attached).

I understand that if my application is approved my tobacco user premium discount will expire after twelve months, at which time I will be required to reapply for the premium discount. I understand further that if it is determined that I have provided false or misleading information in order to receive the tobacco user premium discount that 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: 334-517-9728