Tobacco & Preventive Care Affidavit

Please complete this confidential form by: **September 15, 2022**

This Affidavit will be used for the 2022-2023 health insurance plan year. You must complete both the Tobacco & Nicotine AND Preventive Care sections EACH YEAR to qualify for the annual incentives.

PLEASE NOTE: If your spouse is enrolled on the health insurance plan, they must also complete this annual affidavit.

SECTION 1: PERSONAL INFORMATION

Enrolled Spouses must complete a separate form.

Participant Name: _____

Employee ☐ Spouse ☐ If spouse, list employee name: _____

E-mail: _____

SECTION 2: TOBACCO & NICOTINE USE

A $80 per pay surcharge will be applied if this section is not completed, or if you are a tobacco user.

☐ I attest that I am tobacco-free and have not used any tobacco product in the last 3 months preceding signing this affidavit. I also commit to being tobacco-free for the next 12 months. Tobacco-free means I have not used cigarettes, pipes, cigars, chewing tobacco, snuff, or any other type of smoking or smokeless tobacco, including forms of vaping. I understand that one usage of any tobacco product is considered tobacco use.

☐ I am currently a tobacco user and understand I am eligible for the Tobacco Cessation program at no cost to me.

Contact the FREE Medical Mutual QuitLine tobacco cessation program at **(866) 845-7702** to enroll.

By signing this section, you certify the above tobacco use status. Please read the consent information below before signing.

I understand I will be eligible to have the Tobacco surcharge waived following completion of the Tobacco Cessation program offered. If my Tobacco status should change and I begin using tobacco products subsequent to the submission of this Affidavit, I agree to notify the Benefits Department immediately to complete an updated Affidavit and that I am subject to the Tobacco surcharge. I also understand knowingly and intentionally providing false or misleading information for the purpose of defrauding or attempting to defraud my employer may result in disciplinary action, up to and including termination of employment.

➡ **Participant Signature:** _____ Date: _____

SECTION 3: PREVENTIVE CARE VERIFICATION

A $40 per pay surcharge will be applied if this section is not completed.

Metabolic syndrome values have been discussed with patient, along with the health detriments of tobacco use.

Accepting preventive care visits between:
9/16/21-9/15/22

Date of Screening M M - D D - Y Y

Provider Stamp or Signature:
I hereby acknowledge the undersigned patient is up-to-date with recommended preventive care including, but not limited to, glucose; BMI; blood lipids; breast, cervical, and colon cancer screenings; general health risk status, tobacco use and screenings as age, gender, and family/medical history appropriate. Once the form is completed and signed, please return to patient for submission.

Provider Name: _____ Provider Signature: _____

Date: _____ Phone Number: ( ) _____ - _____

License Number: _____

*If laboratory tests are due your plan pays a certain amount for some lab tests. Discuss cost and be sure you are choosing a lab provider that does not charge above the set rate for each test.

SECTION 4: CONSENT

By signing this form, I certify the following:

I hereby certify the information on this form is accurate to the best of my knowledge and I authorize this data to be provided to my employer for the purpose of administering my/my spouse's employer sponsored wellness program. I understand the nature and content of this document, I am of legal age, and I am fully competent to execute this form.

I authorize my/my spouse's employer, and Britton Gallagher or other contracted vendors, and/or other partners engaged by my/my spouse's employer health plan to conduct services in connection with my/my spouse's employer wellness program ("Program"). My participation in this initiative and the Program is voluntary.

I authorize the use and disclosure of health and personal information about me for purposes of my participation in the Program. I understand my employer will determine my health insurance payroll contributions based upon my participation in the Program. If I do not complete and submit this form by the deadline, I understand surcharges will be automatically added to my medical plan contributions.

This authorization will expire 12 months from the date of my new medical plan year or one year from date of this document, whichever is later. Refer to your employer for more information to determine the impact on your payroll contributions.

➡ **Participant Signature:** _____ Date: _____

Submit Fully Completed Form to: WellnessForms@Marcs.com

NOTE: You are responsible for submitting this fully completed form for processing by the due date above. Illegible forms will not be processed and all information must be submitted to avoid surcharges.

A DIVISION OF HEALTH & WELLNESS BRITTON GALLAGHER