Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Tobacco Affidavit

PLEASE PRINT CLEARLY

Employer: City of Hamilton Select One: Male ○ Female ○

First Name: _____ Last Name: _____

Are you: City Employee ○ Covered Spouse ○ City Work Location (or Department): _____

Plan Coverage: Single ○ Employee+1 ○ Family ○ Social Security Number (last 4): _____

If Employee+1 or Family Plan, list your spouse's first and last name: _____

Date of Birth: _ _ / _ _ / _ _ _ _ Member Number (from Insurance Card): _____

Home Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Email: _____

Preferred Means of Contact: Phone ○ Email ○

"Use of tobacco" means all uses of tobacco, including inhaling, exhaling, burning, vaping, or carrying any lighted cigar, cigarette, pipe, alternative nicotine product, other lighted smoking device or papers for burning tobacco, or any other plant; chewing tobacco snuff, or any other matter or substances that contain tobacco within the last thirty (30) days.

*** *Future **Living Well Program** requirements will require that participants not "use" tobacco within the prior six (6) months to be considered tobacco-free.* ***

"Alternative nicotine product" means an electronic cigarette or any other product or device that consists of or contains nicotine that can be ingested into the body by any other means, including, but not limited to, chewing, smoking, absorbing, dissolving, or inhaling. Nicotine gum, nicotine patches, or any other nicotine replacement therapy aids are excluded.

To be considered a non-tobacco user and eligible for 40% of the 2019 Living Well Program contribution:

- Covered employees (and eligible spouse's) have not used any tobacco product for the last 30 days
- Covered employees (and eligible spouse's) that have used tobacco in the last 30 days, but have provided proof of completion of the Reasonable Alternative

Please mark your designation below:

I have read and understand what constitutes tobacco use. I herby confirm:

❑ **YES** – I and my covered spouse are tobacco-free.

❑ **YES** – I am not tobacco-free, but will complete the Reasonable Alternative. I understand it is my responsibility to return a completion certificate to Kettering Health Network by the program deadline. My spouse is tobacco-free.

❑ **YES** – I am tobacco-free. My covered spouse is not tobacco-free, but will complete the Reasonable Alternative. I understand it is my responsibility to return a completion certificate to Kettering Health Network by the program deadline.

❑ N**O** – Either myself or my spouse are not tobacco-free, and we will not complete the reasonable alternative. I understand that 40% of the HSA/HRA contribution is contingent on this requirement, and by selecting this option I do not qualify for 40% of the HSA/HRA contribution.

I certify that this information is true and correct. I understand that providing false information on this form would be considered a violation of my employer's standards of conduct as falsification of a form, and that this may result in disciplinary action up to and including termination of employment as determined by The City of Hamilton.

Signature of Participant: _____ Date: _____

Please submit completed form:
- Scan and email to healthyhamilton@ketteringhealth.org
- Send via secure fax: (513)867-6900