

SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
Employee Insurance Program
Certification Regarding Tobacco Use

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| SUBSCRIBER NAME: | SUBSCRIBER BIN OR SSN: |
| NON-TOBACCO-USER PREMIUM | <p><input type="checkbox"/> I certify that I am eligible for the Non-Tobacco-User Premium by checking this box and returning this form to the Employee Insurance Program ("EIP"). By checking this box, I certify truth and understanding of the following:</p> <ul style="list-style-type: none"> ❖ I certify that all persons covered on my health insurance coverage through EIP (including myself and any dependents) are not currently using, and have not used, any tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last 6 months. ❖ I certify that if this information changes at any time in the future, while I have health insurance coverage through EIP, I will notify EIP of such change within 30 days through completion and re-submission of this form. ❖ I certify that this information is true and correct to the best of my knowledge. ❖ I understand that if it is determined that I (or any of my covered dependents) have used tobacco products within the last 6 months or if I (or any of my covered dependents) start using tobacco products subsequent to the date of this certification without notifying EIP, I will be subject to penalties including, but not limited to, payment of premium difference since last certification plus a 10% penalty and elimination of tobacco user's out-of-pocket maximum for current year and subsequent year. ❖ I understand that all premium changes will be prospective. I will not be refunded any part of the Tobacco-User Premiums I have already paid. |
| TOBACCO-USER PREMIUM | <p><input type="checkbox"/> I acknowledge that I will pay the Tobacco-User Premium by checking this box. I declare that one or more persons covered on my health insurance coverage through EIP uses tobacco products in some form or that I choose not to disclose my status as it relates to tobacco use. I understand that by not making an election I am choosing to pay the Tobacco-User Premium. Please do not send me this certification again unless upon request.</p> |

SUBSCRIBER SIGNATURE

DATE

BENEFITS ADMINISTRATOR SIGNATURE

DATE

(Benefits Administrator's signature is required for active employees and for retirees and survivors of local subdivisions)

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THE AGENCY RESERVES THE RIGHT TO REVISE THE TERMS AND CONDITIONS OF THIS DOCUMENT IN WHOLE OR IN PART AT ANY TIME. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

11/09 If you have any questions, please call Customer Service at 803-734-0678 or toll-free at 888-260-9430.

Return this completed form to the Employee Insurance Program, PO Box 11661, Columbia, SC 29211.