

Tobacco Use Change Form

Kentucky Employees' Health Plan
Department of Employee Insurance
KEHP.KY.GOV • 1-888-581-8834

TOBACCO USE CHANGE FORM

Name:	Personnel Number:	SSN:	
Organizational Unit:	Company Number:	Company Name:	
Address Street:	City:	State:	Zip:

The Commonwealth of Kentucky is committed to fostering and promoting wellness and health in the workforce. On a monthly basis, KEHP offers discounted premium contribution rates to non-tobacco users as a part of its wellness program. Each KEHP member has at least one opportunity per plan year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees/retirees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at 888-581-8834 or 502-564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

If you have a change in your tobacco use status or are requesting an alternative standard to receive the monthly reward based on your tobacco use, please complete this form in its entirety and return it to your Insurance Coordinator or HR Generalist. All changes will be made prospective beginning on the first day of the month following the signature date on this form. There will be no refunds on monthly premiums already paid except that in the event information was processed incorrectly on your behalf by your Insurance Coordinator/HR Generalist or the Department of Employee Insurance, the change will be made to correspond with the effective date of your original election and you will be refunded for premiums up to 90 days that were paid in error.

TOBACCO USE INFORMATION
Check the applicable box below: ☐ I mistakenly certified that either I or a spouse or dependent covered under my insurance plan used tobacco regularly within the past six months when, in fact, neither I nor my spouse or dependent used tobacco regularly. ☐ I certified during the application process that within the past six months I or a spouse or dependent covered under my plan used tobacco regularly. I now certify that within the past six months, I have not used tobacco regularly and no person covered under my insurance plan has used tobacco regularly. [Attach proof of completion of a tobacco cessation program if applicable]. ☐ I certified during the application process that within the past six months I or my spouse or a dependent covered under my insurance plan used tobacco regularly. Since then, the tobacco user became ineligible for coverage or was otherwise terminated from my plan. I now certify that within the past six months, I have not used tobacco regularly, and no person covered under my insurance plan has used tobacco regularly. ☐ I certified during the application process that, within the past six months, neither I nor my spouse or a dependent covered under my insurance plan used tobacco regularly. However, since the initial certification, either I or a spouse or a dependent covered under my insurance plan began to use tobacco regularly. ☐ I certified during the application process that, within the past six months, I/my spouse/my dependent (circle one) covered under my insurance plan used tobacco regularly. I/my spouse/my dependent (circle one) is unable to meet the non-tobacco use standard and request(s) a reasonable alternative method to receive the monthly non-tobacco user discounted premium contribution rate.
NOTE: Regularly means you have used tobacco four or more times per week on average excluding religious or ceremonial uses.
NOTE: “Tobacco” means all tobacco products including, but not limited to, cigarettes, pipes, chewing tobacco, snuff, dip, and any other tobacco products regardless of the frequency or method of use.
NOTE: “Dependent” means, for the purpose of the Tobacco Use Change Form, only those dependents who are 18 years of age or older.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Employee/Retiree Section	
Printed Name:	Date:
Signature:	

My signature below certifies that all signatures and signature dates affixed to this affidavit are correct to the best of my knowledge.

Insurance Coordinator/HR Generalist Section		
Printed Name:	Date:	
Signature:	Agency:	Agency Number: