

**STATE EMPLOYEES' INSURANCE BOARD
NON-TOBACCO USER DISCOUNT
APPLICATION**

CONTRACT HOLDER NAME: (please print)	SOCIAL SECURITY NUMBER #:

Declaration

I declare that I am not currently using or have used tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last 12 months.

If my spouse is covered as a dependent under the State Employees' Health Insurance Plan (SEHIP), I declare further that my spouse is not currently using or has used tobacco products in any form within the last 12 months.

I understand that if it is determined that I (or my spouse if covered as a dependent under the SEHIP) have used tobacco products within the last 12 months or if I (or my spouse if covered as a dependent under the SEHIP) start using tobacco products subsequent to the date of this application without notifying the State Employees' Insurance Board, that I will be subject to disciplinary action, including termination of employment, 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: _____

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 health to provide to the State Employees' Insurance Board any information related to my/our use of tobacco products.

Signed: _____
Contract Holder

Date: _____

Signed: _____
Spouse (if covered under SEHIP)

Date: _____

Return to: State Employees' Insurance Board
201 South Union Street, Suite 200
Post Office Box 304900
Montgomery, AL 36130-4900
334-263-8341 / 1-866-836-9737 / Fax: 334-263-8541