



Tobacco Usage Status Change Form

Employer use only

Approved by: _____

Approved date: _____

Effective date: _____

Use this form to change your tobacco usage status at any time throughout the plan year. Applicable premium changes will take effect the first of the following month.

Employee information

Employee ID, E number or Social Security number		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Date of birth (mm/dd/yyyy)
Last name	First name	M.I.	
Home phone number	Work phone number	Medicare eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Personal email		Work email	
Address	<input type="checkbox"/> Check if new address	Apartment or space#	
City	State	ZIP	County
Ethnicity (Select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			
Race (Select at least one. If selecting more than one, circle one as primary):			
<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Other	<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown

Tobacco usage (Responses in this section are required)

Employee In the last 12 months (Select one): <input type="checkbox"/> I have used tobacco products <input type="checkbox"/> I have not used tobacco products <input type="checkbox"/> I have never used tobacco products	Spouse/Domestic partner In the last 12 months (Select one): <input type="checkbox"/> I do not currently have a spouse/domestic partner <input type="checkbox"/> My spouse/domestic partner has used tobacco products <input type="checkbox"/> My spouse/domestic partner has not used tobacco products <input type="checkbox"/> My spouse/domestic partner has never used tobacco products
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Employee signature and authorization

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

This election supersedes all elections and submissions I previously made for OEBC coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for perjury.

Employee signature _____

Date _____

**Submit the completed form to your employer.
Do not submit this form to OEBC.**