PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Tobacco-use Midyear Change

- Office Use Only -

Approved by ___ Date___

Effective Date_____

ONLY use this form to change your or your spouse/domestic partner's status in the Tobacco-use Program.

1. Contact Information

PEBB Benefit Number (P########), Employee ID, University ID

Last Name | First Name | MI | Agency # | Gender ☐ F ☐ M

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

Contact Address ☐ Check if New Address | Apt # | City | State | Zip

Residence Zip	Work Zip	Work Email	Personal E-mail (optional)
Date of Birth (mm/dd/yyyy)		Work Phone	Home Phone (optional)

2. Explanation of change (check the change and to whom it applies, and provide the date)

	Change	Applies to	Date
☐	Quit using tobacco	☐ Self ☐ Spouse or domestic partner	
☐	Never used tobacco	☐ Self ☐ Spouse or domestic partner	
☐	Medical provider determined that a medical condition makes it unreasonably difficult to try to quit using tobacco.	☐ Self ☐ Spouse or domestic partner	
☐	Medical provider advised not to attempt to quit using tobacco	☐ Self ☐ Spouse or domestic partner	
☐	I have not used tobacco products in the previous 12 months (This will result in optional life premium adjustment)	☐ Self ☐ Spouse or domestic partner	
☐	Started using tobacco or I have used in the previous 12 months. (This will result in deductions to my pay each month and an increase in optional life premiums)	☐ Self ☐ Spouse or domestic partner	

3. Employee Signature and Authorization.

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan.

I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay.

I understand that:

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

I also understand that if I fail to report on this enrollment form a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

This form supersedes all forms and submissions I previously made for PEBB 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 false claims.

_____ _____

Employee Signature Date

Submit completed form to your agency payroll or university benefits office.

Keep a copy of your benefit forms for your records.

Any alteration of this form may result in it being ineffective.