



## Conservation Employees' Benefits Plan

### Tobacco-Free Attestation

Note: This Attestation must be filled out by the subscriber and spouse (if both are enrolled in the medical insurance plan) **each plan year** in order to receive the discounted monthly insurance premiums. Please return to Human Resources Division/Benefits Section/Central Office.

Please check the appropriate box:  Active Employee  Retiree  2014  2015

#### Subscriber Information & Attestation

Name (Last, First, Middle Initial): Social Security Number (last 4):

XXX-XX-\_\_\_\_

Address: Date of Birth (MM/DD/YYYY):

City, State, Zip Code

I will not use tobacco products. If I begin using tobacco products, I will notify Human Resources Division by phone, fax or mail immediately to adjust my monthly premium beginning with the next pay cycle.

I understand that providing false information may subject me to repay the discount I received, and may also subject me to fines and/or discipline.

Signature: Date (MM/DD/YYYY):

This Attestation will not be completed unless signed by the subscriber whose name appears above.

#### Spouse Information & Attestation (if on the medical insurance plan)

Name (Last, First, Middle Initial): Social Security Number: (last 4):

XXX-XX-\_\_\_\_

Address: Date of Birth (MM/DD/YYYY):

City, State, Zip Code

I will not use tobacco products. If I begin using tobacco products, I will notify Human Resources Division by phone, fax or mail immediately to adjust my monthly premium beginning with the next pay cycle.

I understand that providing false information may subject me to repay the discount I received, and may also subject me to fines and/or discipline.

Signature: Date (MM/DD/YYYY):

This Attestation will not be completed unless signed by the spouse whose name appears above.