



Employee's Name: _____

Tobacco Use Affidavit

If you enroll in one of the medical plans, you must complete this Affidavit to indicate the use, or non-use, of tobacco products.* Meadows Regional Medical Center will charge the \$25 per pay period tobacco surcharge if you do not complete and return the Affidavit.

* Tobacco products include all forms of cigarettes, cigars, smoking tobacco, chewing tobacco, snuff, and any other product containing at least 50 percent tobacco regardless of the number of times, frequency or method of use.

Please initial one of the three statements:

_____ Neither I nor my covered dependents have ever used tobacco products.

_____ I or my covered dependents have used tobacco products but not within the past six months.

_____ I or my covered dependents currently use tobacco products.

Who uses tobacco: ☐ Employee

☐ Dependent (spouse and/or children)

I do hereby attest that the above information is true and correct to the best of my knowledge. I understand that Meadows Regional Medical Center may, at its discretion, conduct future testing to confirm compliance with non-tobacco use. I also understand that my department head will receive a list of all employees in my department who have submitted a signed Affidavit indicating Non-tobacco Use. I further acknowledge and understand that I may be subject to disciplinary action up to and including termination of employment, if I knowingly and willfully make a false or fraudulent statement or representation to Meadows Regional Medical Center regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20. I am hereby notified that participants in the LifeStyles program who are found to have falsified the affidavit will be switched to the Standard program immediately, pending the outcome of the investigation.

It is my responsibility to complete a new form within 30 days should this information change.

Employee Signature

Date

Please have your supervisor sign the form below confirming that he or she is aware that you are claiming this benefit.

Supervisor Signature

Supervisor's printed name

To Be Completed By The Benefit Coordinator:

Medical Plan:	Department:
Authorized Signature:	Date: