

*Lexington-Fayette Urban County Government  
Tobacco Use Certification*

**By answering NO, I certify the following:**

- I certify that I, and/or my spouse covered by the LFUCG Health Insurance Plan, have not used **ANY TOBACCO PRODUCT** (including, but not limited to, cigarettes, cigars, e-cigarettes, pipes, chewing tobacco, other oral tobacco products, or any product containing nicotine) within the last **TWO (2) MONTHS** or have provided signed notification from a physician indicating it is medically inadvisable to quit using tobacco or quitting would be unreasonably difficult due to a medical condition.
- I certify that if the above information changes at any time in the future, while I am covered by the LFUCG Health Insurance Plan, that I will notify the LFUCG Division of Human Resources **WITHIN FIVE (5) WORKING DAYS** of the change through completion and resubmission of this form.
- I certify that I understand that I, and/or my spouse covered by the LFUCG Health Insurance Plan, may be subjected to periodic nicotine urine testing during Calendar Year 2017.
- I certify that I understand that if it is determined that I, or any other family members covered by the LFUCG Health Plan, have used tobacco products within the last two months or if I start using tobacco products subsequent to the date of this certification without notifying the LFUCG Division of Human Resources, I will be ineligible to receive the Non-Tobacco User Credit for the LFUCG Health Insurance Plan.
- I certify that I understand that if it is determined that I, and/or my spouse covered by the LFUCG Health Insurance Plan, have used tobacco products within the last two months or begin using tobacco products subsequent to the date of this certification, that I may be responsible for the difference in premiums for the duration of the plan year, including past premiums.
- I certify that I understand that application of the non-tobacco user credit is **PROSPECTIVE**; that is, I will not be eligible to receive any refunds for previously paid premiums.

**By answering YES, I certify the following:**

- I certify that I and/or my spouse covered by the LFUCG Health Insurance Plan have, within the last **TWO MONTHS**, used tobacco products **OR** elect not to disclose my tobacco use to the Lexington-Fayette Urban County Government.
- I certify that I understand that I will be ineligible to receive the non-tobacco user credit for health insurance premiums offered to non-tobacco users of the LFUCG Health Insurance Plan.

PLEASE NOTE: Failure to provide an answer will result in the employee being ineligible to receive the non-tobacco user credit.

No	Yes
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Your Name (Please Print)	Employee Number
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No	Yes
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Spouse's Name (Please Print)	Birth Date
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Employee Signature	Date
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**I hereby certify that the above information is true to the best of my knowledge and understand my responsibilities in regards to informing the LFUCG Division of Human Resources regarding a change in my status. I understand that providing false information on this form constitutes INSURANCE FRAUD.**