Tobacco & Nicotine Affidavit



Submit form to: Human Resources Manager of your Department

All information is required to process your form. This form must be completed and received no later than October 31, 2013. NO EXCEPTIONS!

Section 1	: Participant Information (Pi	ease Print Clearly)			
Full Legal	Name:(First)	(MI)	(Last)		
□ Employ	ee □ Spouse				
Age:	Date of Bi	rth://		□ Female	
Employee	e/Member ID:				
Email Add	dress:		Phone: ()	-	
	2: Participant Affidavit eck the one box that best representest that:	ents to your use of tobacco a	and/or nicotine products.		
-	I do not use tobacco or nicotine	e products			
	I use tobacco or nicotine produ I understand that I will not rece		s Smoking Tobacco Cessatio	on Program.	
	ser: If you have used tobacco product a tobacco user.	cts (cigarettes, cigars, pipe toba	acco, chewing tobacco, etc.) in	the last six months, you are	
	placement therapy tches, lozenges, gum, or other produ	acts used to quit the tobacco ha	abit that may contain nicotine.		
Section	3: Participant UHC Health	care Assessment Atte	estation		
	I have completed the UHC C	Online Healthcare Assess	ment.		
Section	4: Participant Signature (Required for process	ing)		
	g this document, I duly swear, o knowledge and belief.	on oath according to law, tha	at I have stated herein inform	ation that is true to the	
Participant S	Signature				
Date					

Results provided will not preclude eligibility in any benefit program. If you have questions about this form or the submission process, please contact your local Human Resources representative. All information provided will be kept strictly confidential.