



Tobacco-use Program Midyear Change

- Office Use Only -

Approved by ___ Date ___

Effective Date _____

Use this form ONLY to change your status in the Tobacco-use Program. Submit the form to your agency payroll or university benefits office. If the form is received before the 15th of the month, any change will process with that month's payroll and will be effective the first of the following month. If the form is received after the 15th of the month, any change is processed in the next month's payroll and will be effective starting with the month that follows.

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

1. Contact Information

Last Name	First Name	MI	Agency #	Gender <input type="checkbox"/> F <input type="checkbox"/> M	
PEBB and the plans in which you enroll will send all benefit-related correspondence to your contact address.					
Contact Address	Apt #	City	State	Zip	County
Residence Zip Code	Work Zip Code	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
<input type="checkbox"/> Quit using tobacco	<input type="checkbox"/> Self	
	<input type="checkbox"/> Spouse or domestic partner	
<input type="checkbox"/> Medical provider determined that a medical condition makes it unreasonably difficult to try to quit using tobacco.	<input type="checkbox"/> Self	
	<input type="checkbox"/> Spouse or domestic partner	
<input type="checkbox"/> Medical provider advised not to attempt to quit using tobacco	<input type="checkbox"/> Self	
	<input type="checkbox"/> Spouse or domestic partner	
<input type="checkbox"/> Started using tobacco - (I understand this will result in the following deductions to my pay each month). <ul style="list-style-type: none"> • Employee only: \$25 • Spouse or domestic partner only: \$25 • Employee and spouse or domestic partner: \$50 	<input type="checkbox"/> Self	
	<input type="checkbox"/> Spouse or domestic partner	

3. Employee Signature and Authorization. (Incomplete or altered forms will not be accepted.)

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.