

Employer: City of Hamilton

Select One: Male  Female

PLEASE PRINT CLEARLY

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Are you: City Employee  Covered Spouse  City Work Location (or Department): \_\_\_\_\_

Plan Coverage: Single  Employee+1  Family  Social Security Number (last 4): \_\_\_\_\_

If Employee+1 or Family Plan, list your spouse's first and last name: \_\_\_\_\_

Date of Birth: \_\_ / \_\_ / \_\_\_\_ Member Number (from Insurance Card): \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Means of Contact: Phone  Email

“Use of tobacco/nicotine” means all uses of tobacco, including inhaling, exhaling, burning, vaping, or carrying any lighted cigar, cigarette, pipe, alternative nicotine product, other lighted smoking device or papers for burning tobacco, or any other plant; chewing tobacco snuff, or any other matter or substances that contain tobacco within the last six (6) months.

“Alternative nicotine product” means an electronic cigarette or any other product or device that consists of or contains nicotine that can be ingested into the body by any other means, including, but not limited to, chewing, smoking, absorbing, dissolving, or inhaling. Nicotine gum, nicotine patches, or any other nicotine replacement therapy aids are excluded.

To be considered a non-tobacco/nicotine user and eligible for 40% of the 2019 Living Well Program contribution:

- Covered employees (and eligible spouse's) have not used any tobacco/nicotine product for the last six (6) months
- Covered employees (and eligible spouse's) that have used tobacco/nicotine in the last six (6) months, but have provided proof of completion of the Reasonable Alternative

**Please mark your designation below:**

I have read and understand what constitutes tobacco/nicotine use. I hereby confirm:

- YES** – I am tobacco/nicotine-free.
- YES** – I and my covered spouse are tobacco/nicotine-free.
- YES** – I am not tobacco/nicotine-free, but will complete the Reasonable Alternative. I understand it is my responsibility to return a completion certificate to Kettering Health Network by the program deadline. My spouse (if applicable) is tobacco/nicotine-free.
- YES** – I am tobacco/nicotine-free. My covered spouse is not tobacco/nicotine-free, but will complete the Reasonable Alternative. I understand it is my responsibility to return a completion certificate to Kettering Health Network by the program deadline.
- NO** – Either myself and/or my spouse are not tobacco/nicotine-free, and we will not complete the reasonable alternative. I understand that 40% of the HSA/HRA contribution is contingent on this requirement, and by selecting this option I do not qualify for 40% of the HSA/HRA contribution.

I certify that this information is true and correct. I understand that providing false information on this form would be considered a violation of my employer's standards of conduct as falsification of a form, and that this may result in disciplinary action up to and including termination of employment as determined by The City of Hamilton.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Please submit completed form:

- Scan and email to [healthyhamilton@ketteringhealth.org](mailto:healthyhamilton@ketteringhealth.org)
- Send via secure fax: (513)867-6900