Non-smoker Discount Affidavit

Please review this affidavit carefully and sign and date at the bottom and return it to Human Resources in order to be eligible for a discount. By completing this affidavit, you are confirming that you as well as your spouse (if enrolled in Medical coverage through E.L. Hollingsworth) do not smoke or use tobacco products, and have not done so for the last 12 consecutive months.

If you currently smoke or use tobacco products and would like to quit, you may also receive the discount by completing a smoking cessation program.

By abstaining from smoking and other tobacco products, or completing a cessation program, you will receive discounted health insurance premiums.

By signing this I____________________ (print name) certify that I (& my spouse, if applicable) am not a smoker or tobacco user and have not smoked or used any tobacco products within the last 12 consecutive months or will be completing a E.L. Hollingsworth approved smoking cessation program. I understand that providing false information may subject me to repay the discount I receive.

Please contact Human Resources with any questions or concerns you have regarding the Non-Smoker Discount Affidavit.

Name

Signature

Date