

# Tobacco Use Certification

Premera Blue Cross Blue Shield of Alaska  
 MS 295  
 PO Box 91120  
 Seattle, WA 98111



For Premera USE ONLY		
APPROVED	DISAPPROVED	DATE
		/   /

SUBSCRIBER OR APPLICANT NAME (PLEASE PRINT):			SUBSCRIBER ID #		
HOME ADDRESS (Not PO Box): STREET			DATE OF BIRTH		
CITY	STATE	ZIP	COUNTY	/   /	
MAILING ADDRESS (If different than home address): STREET					
CITY	STATE	ZIP	COUNTY		
TELEPHONE NUMBER - HOME (      )			TELEPHONE NUMBER - WORK (      )		
TELEPHONE NUMBER - CELL			EMAIL ADDRESS		

**PLEASE CHECK THE BOX BELOW THAT APPLIES TO YOU:**

<input type="checkbox"/> I am currently enrolled in an Individual Plan issued by Premera.	<input type="checkbox"/> I am currently enrolled in an Individual Plan issued by Premera, and wish to add my spouse or dependent (please attach completed application).	<input type="checkbox"/> I am currently applying for coverage under an Individual Plan offered by Premera.
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**If you are a new applicant, or you are adding your spouse or dependent, your completed application MUST ALSO be approved by Premera.**

I certify that neither I nor my dependents, for whom I have made application for coverage, have not used tobacco products on average of four or more times per week within the last 6 months preceding the date of this certification.

I understand that this entitles me to the discounted subscription charges applicable to non-tobacco users, for my Premera Individual Plan.

I understand that Premera may require me to re-certify my/our non-tobacco user status in the future, but not more often than once every year.

I understand that I must inform the Membership and Billing Department at Premera, at once, in writing, if I or my dependents begin or resume using tobacco products.

I understand that subscription charges will increase to the full undiscounted rate on the first of the month following the month in which I or my dependents, begin or resume using tobacco products, notwithstanding any provisions of my Individual Contract to the contrary.

I understand that if I fail to truthfully and accurately complete this certification, Premera may adjust my subscription charges retroactively to the full, undiscounted rate. Upon written notification, I must reimburse Premera any amounts reduced from my subscription charges for the period for which I claimed eligibility for the "Tobacco Use Discount." If reimbursement is not made, such amounts will be deducted from future claims and from subscription charges already paid.

_____	_____ / _____ / _____
SIGNATURE OF SUBSCRIBER OR APPLICANT	DATE
_____	_____ / _____ / _____
SPOUSE'S SIGNATURE (IF COVERED OR APPLYING)	DATE
_____	_____ / _____ / _____
DEPENDENT SIGNATURE OF CHILD AGE 18 OR OVER	DATE

**THIS CERTIFICATION, FOLLOWING RECEIPT AND APPROVAL BY PREMERA, BECOMES A PART OF YOUR CONTRACT.**

**Tobacco Use Discount Rates are effective on the first billing period following receipt and approval of this Certification by the Plan. For further information, contact our Customer Service Department.**

Toll Free 1-800-592-6804      TDD for the Hearing Impaired 1-800-842-5357

### Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

### Getting Help in Other Languages

**This Notice has Important Information.** This notice may have important information about your application or coverage through Premera Blue Cross Blue Shield of Alaska. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-508-4722 (TTY: 800-842-5357).

**Español (Spanish): Este Aviso contiene información importante.** Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross Blue Shield of Alaska. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-508-4722 (TTY: 800-842-5357).

**中文 (Chinese): 本通知有重要的訊息。**本通知可能有關於您透過 Premera Blue Cross Blue Shield of Alaska 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-508-4722 (TTY: 800-842-5357)。

**Tiếng Việt (Vietnamese): Thông báo này cung cấp thông tin quan trọng.** Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross Blue Shield of Alaska. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-508-4722 (TTY: 800-842-5357).

**Tagalog (Tagalog): Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon.** Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross Blue Shield of Alaska. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-508-4722 (TTY: 800-842-5357).