

# United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund

2625 Butterfield Rd, Suite 208E ♦ Oak Brook, IL 60523 ♦ 800-621-5133 ♦ FAX 847-384-0197 ♦ [www.ufcwmidwest.org](http://www.ufcwmidwest.org)

## Tobacco Use Affidavit

If you are enrolled in the UFCW Union and Employers Calumet Region Insurance Health Plan, effective January 1, 2021, the Fund will apply a tobacco surcharge of \$40 per week if you currently use tobacco products or have used tobacco products within the last six months. As part of the Election documents, you must complete this Tobacco Use Affidavit and submit it to the Health Fund.

If a surcharge has been applied, you are eligible to remove the tobacco surcharge only after certifying on another Tobacco Use Affidavit that you have been tobacco free for the prior six months.

**NOTE:** Tobacco products are defined as tobacco or tobacco-like products intended for human consumption, and when used orally or inhaled, produces smoke or smoke-like vapor. This includes but is not limited to: cigarettes, cigars, loose tobacco smoked via pipe or hookah, chewing tobacco, snuff, dip, electronic cigarettes and vaporizers.

### TOBACCO USE INFORMATION

Please check the applicable boxes below.

- I certify that I **do not** currently use tobacco products, and I have not used any tobacco products for at least six months prior to the date signed below.
- I have used tobacco products within the past six months and understand that I will be charged weekly via payroll deduction a \$40 Tobacco Surcharge.

#### By signing this form, I certify the following:

1. I have truthfully checked the box above that accurately reflects my use of tobacco products within the past six months.
2. I understand that the tobacco surcharge will apply to me if I have used tobacco products within the past six months and that the surcharge will be automatically withheld from my paycheck and remitted monthly to the UFCW Union and Employers Calumet Region Insurance Fund by my Employer.
3. If I do not complete and submit this form, I understand the tobacco surcharge will be automatically added to my medical plan contributions as described above.
4. I understand that if I currently use tobacco products and stop using tobacco products in the future, I will be eligible to have the tobacco surcharge waived within two pay periods following receipt of a new *Tobacco Use Affidavit* certifying that I have not used tobacco products during the prior 6 months.
5. I understand that if my tobacco use should change and I begin using tobacco products subsequent to the submission of this Affidavit, I agree that I am subject to the tobacco surcharge and will complete an updated *Tobacco Use Affidavit*. Failure to do so could result in repayment of the surcharge retroactively to the beginning of the plan year.
6. I also understand knowingly and intentionally providing false, incomplete or misleading facts or information on the Tobacco Use Affidavit may result in payment of the tobacco use surcharge retroactively to the beginning of the plan year.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Last 4 digits of SSN#

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date