

Member Section: Please provide the following information.

Print clearly.

Name: _____
NAME OF MEMBER REQUESTING EXEMPTION

Subscriber
 Dependent

Subscriber ID#: _____ Date of birth: _____

Physician Section: Please provide the following information.

_____ is participating in a tobacco cessation program*
NAME OF MEMBER REQUESTING EXEMPTION

The cessation program began _____ / _____ / _____ .
DATE

Physician (M.D.), physician assistant or nurse practitioner
signature required

Date

* A qualifying tobacco cessation program may be defined as cessation medication, NC Tobacco Use Quitline coaching, health care provider cessation counseling and/or other physician approved cessation treatments.

Instructions:

1. This form is **COMPLETE** once you have filled in the Member Section and your physician/provider or NC Tobacco Use Quitline confirms your participation in a cessation program by indicating the program start date and by signing and dating the form. **You will need to keep the completed certification form for your records in case the Plan requests a copy of the form during the benefit year.**
2. Upon request by the Plan, you must submit the completed certification form(s) within 15 business days from the date of request. If you mail the form(s), the envelope must be postmarked on or before the 15th business day from the date on the Plan's request letter in order to meet the response deadline.
3. If the Plan receives your completed certification form **NO LATER** than 15 business days from the date on the request letter, and if the start date of the cessation program is prior to the date on the request letter, then you and your covered dependents may remain in the 80/20 Standard Plan for the benefit year. If you do **NOT** submit the completed certification form by the deadline, or if the start date of the cessation program is after the date on the request letter, you and your covered dependents will be moved from the 80/20 Standard Plan to the 70/30 Basic Plan for the rest of the benefit year. You will also forfeit any coinsurance and deductibles already paid under the 80/20 Standard Plan during the benefit year. You and your covered dependents will be eligible to enroll only in the 70/30 Basic Plan for the following benefit year.

If you have questions, please contact the Plan Customer Service (1.888.234.2416),
your Health Benefits Representative or visit www.shpnc.org.