Non- Tobacco User Certification for Employees

To qualify for the discounted contributions under Archer's medical/prescription drug plan, you must certify that you have **NOT** used any tobacco products in the last 180 days.

By signing this Non-Smoker/Non-Vaper/Non-Tobacco User Certification, I certify that:

- I am a non-smoker/non-vaper/non-tobacco user and I have not smoked a cigarette, cigar, pipe, or used tobacco products or electronic smoking devices of any kind in any form in the last 180 days.
- I understand that it is my responsibility to notify Benefits if I should begin to smoke/vape/use tobacco at any future date.
- I understand that Archer may require me to re-certify my non-smoker/non-vaper/non-tobacco user status in the future, but not more than once a year.
- I understand that if I use tobacco or electronic smoking devices, I will lose my discount and that my medical and prescription drug plan employee contributions will immediately increase as a result.
- I understand that any dishonest or false representation of my non-smoking/non-vaping/non-tobacco use status will result in immediate loss of my discount. This may result in Archer requiring me to reimburse them for any amounts reduced from my contributions for the period in which I claimed I was eligible for the discount.
- If I fail to make appropriate reimbursement payments, Archer may deduct such amount from my paycheck.

If you use tobacco and are enrolled in one of the Archer & Greiner medical/prescription drug plans, you may qualify for an opportunity to earn the same incentive through different means. Contact the Benefits Department for more details regarding reasonable alternatives to our wellness program.

IMPORTANT: If you **DO NOT** understand the information above, please contact Benefits **PRIOR TO** completing your enrollment. By submitting this certification it will be deemed that you read, understand and adhere to the requirements listed above.

PRINT EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

DATE: _____

To be completed by the Benefits Department

_____

Date Received **Initials**