Publix Super Markets, Inc.
Tobacco Usage Affidavit

At Publix, we are committed to helping our associates and their family members quit tobacco, avoid the harmful effects of smoking and live healthful lifestyles. A tobacco-free discount is offered to associates and their families enrolled or enrolling in the BCBS PPO Plan who are tobacco free. The discount also is offered to tobacco users who participate in and successfully complete the Tobacco Cessation Program offered by Publix. For detailed information, please refer to the Tobacco Cessation Program Information available on PASSport.

I am completing and submitting this Tobacco Usage Affidavit (Affidavit) to report tobacco use for me and my family members enrolling or enrolled in the BCBS PPO Plan (covered family members). This Affidavit may be used to report a change in the tobacco use status of me and/or any of my covered family members.

Select one:	☐ New Enrollment	☐Tobacco Use Status Change	☐Open Enrollment

By affirmatively checking one of the three statements below, I hereby CERTIFY the tobacco use status for me and any of my covered family members, including my spouse, dependents and/or adult children, as of the date I am signing this Affidavit. I UNDERSTAND that for purposes of this Affidavit, "tobacco" includes cigarettes, cigars, cloves, chewing tobacco, dipping tobacco, electronic cigarettes, snuff, pipes, vape products and **ANY OTHER** types of smoking or smokeless tobacco, and inhaled substances, used on a regular, infrequent, social or casual basis.

Please **select one** of the following statements that accurately applies to you:

☐ I, and all of my covered family members, do NOT use ANY tobacco products.

☐ I, and/or one or more of my covered family members, use tobacco. I CERTIFY that I and/or my covered family member(s) who use tobacco agree to participate in the Tobacco Cessation Program (Program) offered by Publix, as defined in the Tobacco Cessation Program Information available on PASSport, and to successfully complete the Program, as defined by Publix in its discretion. I ACKNOWLEDGE that I will receive a discount on my health insurance pay period deduction in exchange for participation in and successful completion of the Program.

☐ I, and/or one or more of my covered family members, use tobacco. I/we decline to participate in the Tobacco Cessation Program (Program) offered by Publix. I ACKNOWLEDGE that I am forfeiting a discount on my health insurance pay period deduction.

Provide Plan Member information:
Please provide your and your covered family members' information and tobacco use status below.

Associate Last Name	Associate First Name	Publix Personnel Number	Tobacco User
			☐ Yes ☐ No

Relation to Associate	Family Member Last Name	Family Member First Name	Social Security Number	Tobacco User
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

YOU MUST ACKNOWLEDGE, SIGN AND DATE THE BACK OF THIS AFFIDAVIT AND RETURN IT TO THE PUBLIX GROUP BENEFITS DEPARTMENT.

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You must read each of the following acknowledgements and check the box below:

I UNDERSTAND that I MUST immediately notify the Publix group benefits department by completing and submitting a new Affidavit if the tobacco use status reported on this Affidavit changes for me or one or more of my covered family members at any time in the future. A blank Tobacco Affidavit form is available on publix.org (PASSport). For changes in tobacco use status resulting in my becoming eligible for a tobacco-free discount, I ACKNOWLEDGE that the tobacco-free discount generally will be effective the day the Publix group benefits department receives my properly completed and executed Affidavit.

I UNDERSTAND that it is my sole responsibility to ensure the tobacco use status of my spouse, dependents and adult children is accurate as reported on this Affidavit, and that I am responsible for ensuring my spouse, dependents and adult children immediately notify me of any changes to their tobacco use status in the future.

I UNDERSTAND that failure to notify the Publix group benefits department of a change in tobacco use status by completing and submitting a new Affidavit **may result in employment disciplinary action being taken against me for dishonesty**, up to and including termination of employment and retroactive collection of tobacco-free discounts.

I UNDERSTAND that I and/or any of my covered family members may be asked at any time to submit to tobacco and/or nicotine usage testing, including saliva, blood, hair, urine or other testing. I further UNDERSTAND that my or my covered family members' failure to submit samples for such testing will cause me to be treated as an associate who failed to meet the requirement stated above for changes in tobacco use status and **may result in employment disciplinary action being taken against me for dishonesty**, up to and including termination of employment and retroactive collection of tobacco-free discounts.

☐ By checking this box, **I DECLARE THAT I HAVE READ, UNDERSTAND AND AGREE with all information on, and terms of, the Tobacco Usage Affidavit. I CERTIFY the tobacco use status and plan member information reported on this Tobacco Usage Affidavit. I further CERTIFY I am fully competent to execute this Affidavit.**

_____ _____/_____/_____
Associate's Signature Date

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an enrollment form containing any false, incomplete or misleading information is guilty of a felony in the third degree.