PUBLIC EDUCATION BENEFITS TRUST

Please return completed form to your District Benefits Administrator.

Smoker Declaration Form

Part 1: Employee and / or Spouse Information		
Employee's Name (please print)	Gender ☐ Male ☐ Female	District ID Number
Spouse's Name (if applicable, please print)	Gender ☐ Male ☐ Female	District #

Part 2: Declaration		
Please check the appropriate box	Employee	Spouse (if applicable)
1. I certify as a true fact that I have used tobacco products during the 12 month period immediately preceding the date written below, beside my signature.	☐	☐
OR		
2. I certify as a true fact that I have **not** used tobacco products during the 12 month period immediately preceding the date written below, beside my signature	☐	☐

I understand and agree that the premiums charged for my (or my spouse's) Optional Life insurance coverage are based in part on the statements given by me (or my spouse) on this form. I certify that the statements are accurate, true and complete in all respects. In the event that any such statement is inaccurate, untrue or incomplete in any respect, I understand and agree that all insurance coverage is voidable by the insurer. I further agree that in such event the insurer's liability is limited to paying to the designated beneficiary/beneficiaries the amount of any premium I paid for insurance coverage.

Employee's Signature _____ **Date Signed (mm/dd/yyyy)** _____

Spouse's Signature (if applicable) _____ **Date Signed (mm/dd/yyyy)** _____