MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
Tobacco Use Attestation Form

All sections of the form below must be completed in order for the form to be processed. Please print in blue or black ink.

LAST NAME:	FIRST NAME:	MI:	LAST FOUR OF SSN:	
HOME ADDRESS:	CITY:		STATE:	ZIP:
PERSONAL TELEPHONE NUMBER:	PERSONAL EMAIL ADDRESS:			

- **Please initial the appropriate box below to indicate whether or not you use tobacco on a regular basis.**
- **If you are a regular user of tobacco, please indicate whether or not you are interested in receiving information about the Mississippi State and School Employees' Health Insurance Plan's (Plan) free tobacco cessation programs.**

NON-TOBACCO USER

☐ I attest that I do not regularly use a tobacco product in any form (cigarettes, cigars, pipe, oral tobacco products, etc.).

I certify that all information provided by me on this form is complete and accurate.

Signature ______________________ Date ______________________

TOBACCO USER

☐ I acknowledge that I regularly use a tobacco product in some form (cigarettes, cigars, pipe, oral tobacco products, etc.).

☐ I am interested in receiving information about tobacco cessation programs offered by the Plan.

I certify that all information provided by me on this form is complete and accurate.

Signature ______________________ Date ______________________

Form Submission:

- If you are an active employee, please return your form to your employer's Human Resources Department.
- If you are a non-Medicare retiree or COBRA participant, please mail or fax your form to:

Blue Cross & Blue Shield of Mississippi
P.O. Box 23734
Jackson, MS 39225-3734
Fax: (601) 664-5342

For more information visit KnowYourBenefits.dfa.ms.gov