TOBACCO USE AFFIDAVIT

Please complete this section if you and your family member(s) are covered on The Langdale Company Employee HEALTH Benefit Plan (does not apply to the Dental Plan). Please initial the statement below that applies to you.

_____I certify I and all my family member(s) covered under my *The Langdale Company Employee Health Benefit Plan* have not used tobacco or tobacco products (including, but not limited to cigarettes, snuff, chewing tobacco, cigars, pipe tobacco and other similar products in any quantity) during the last twelve (12) months. I further understand that if either myself or another covered family member begins tobacco use during the Plan Year, I will report it to the Human Resources (HR) Representative and agree to begin paying the monthly **$80.00** tobacco surcharge immediately.

_____I certify that either myself or one or more of my family members covered under *The Langdale Company Employee Health Benefit Plan* uses tobacco products (as described above). I further acknowledge that as a result, I will be charged the monthly **$80.00** tobacco surcharge for the Plan Year. I do understand that if all tobacco users in my family stop tobacco use and complete a smoking cessation program or some other reasonable alternative, the surcharge will be discontinued if proof/ paperwork is provided to the HR Department within thirty (30) days.

Note: If it is unreasonably difficult or medically inadvisable due to a medical condition for you or your covered family member(s) to achieve the standards to avoid the surcharge under ***The Langdale Company Tobacco Cessation Program***, contact HR. We will work with you to develop a reasonable accommodation so that you can qualify for the incentive.

I understand and acknowledge that falsification of information on the Tobacco Use Affidavit will result in prospective loss of all group health insurance coverage for one (1) year and may incur termination of employment.

Employee Signature:_____ **Date: _____**