

Sweetwater County Employee Health Care Plan
Deductible Reduction for Yearly Certifications for
Calendar Year 2011 (1-1-11 to 12-31-11)

The Sweetwater County Employee Health Care Plan provides for a significant reduction in the employee's annual deductible for each of the three certifications below (Non-Tobacco User Certification \$500 and \$250 each for the Cholesterol and Blood Pressure Screening Waivers). Cholesterol and blood pressure certifications must be based on commonly accepted tests that have been performed by a properly licensed health care provider, (e.g., Physician, PA, Nurse Practitioner, etc.), within 24 months of the date of the certification. This completed form must be received in the County Clerk's Office by no later than December 3, 2010 preceding the calendar year for which the employee is to receive the deductible reduction for which he/she is eligible.

Certification Employee is Non-Tobacco User: By my signature below, I certify that I do not use tobacco products of any kind, including cigarettes, cigars, pipe, smokeless, (e.g., chew, snuff, etc.). I acknowledge that by refraining from tobacco use, I will realize a reduction in my health insurance deductible with a real value of \$500. I further acknowledge that if I were to begin using the tobacco products referenced herein, I would have a duty to rescind this certification. I understand that I may be subject to repayment of the fraudulently obtained reduction in my deductible and/or disciplinary action, up to, and possibly including termination of my employment for submitting a false certification of non-tobacco use, or for not rescinding this certification upon commencing or resuming tobacco use.

_____/_____
Employee Signature / Date

Cholesterol Screening Waiver: By my signature below, I certify that I have completed a cholesterol screening within the past (2) two years and to the best of my knowledge my cholesterol levels are either within acceptable limits, or that I am under professional care to manage my cholesterol levels.

_____/_____
Employee Signature / Date

Blood Pressure Screening Waiver: By my signature below, I certify that I have completed a blood pressure screening within the past (2) two years and to the best of my knowledge my blood pressure levels are either within acceptable limits, or that I am under professional care to manage my blood pressure levels.

_____/_____
Employee Signature / Date