

Employee Non-Tobacco User Affidavit

I certify that I or my covered dependents on TeamHealth's health insurance plan (i) do not presently smoke or use tobacco products, and (ii) have not smoked or used tobacco products during the 6 months immediately preceding this affidavit. I understand that falsification of information is a violation of Company policy, which is subject to disciplinary action up to and including termination of employment. "Smoke or use tobacco products" for purposes of this affidavit means any use of cigarettes, pipes, cigars or any other tobacco products regardless of the number of times, frequency or method of use.

I, the undersigned, have read the above and understand the penalties that may apply if the information in my statements is false.

Signature

Date

Please check the appropriate box:

- I or my covered dependents have recently quit using tobacco and have been tobacco-free for six months.
- Neither I nor my covered dependents have ever used tobacco; or it has been over a year since I or my covered dependents have used tobacco.

Print Name _____

Employee Number _____ OR Last four digits of SSN _____

Fax to 865-539-3073 or 888-422-0106