MUS_EB
Montana University System
Employee Benefits

MUS - Tobacco Cessation Contract

Please answer each question below. Partially completed contracts will be returned.

1. Name: ____ Date of birth:______________________

2. Daytime Telephone number: (____)________________ Email:__________________________

3. Mailing address:____

   ____

4. Are you on the MUS Medical Benefits Plan? Yes _____ No _____
   Which plan? Allegiance:____ BCBS:_____ New West:_______ Peak:________ MAPP:___ ___

   Policy holder's full name as it appears on insurance card: _________________________________

5. Do you currently use tobacco products? Yes_____ No_____

6. If so, what do you use and how often? Cigarettes____ How often______
   Spit tobacco ______ How often _____ Other ______ How often_____

7. How long have you used tobacco products? ____

8. Have you ever tried to quit? ____
   If yes, what methods did you try? ____
   What was the longest span of time you were tobacco free? ________________________________

9. On a scale of 1-10; 1 being not ready, and 10 being ready now, how ready are you to quit using tobacco?
   ____

10. Do you want to quit because someone else wants you to quit? _____
    If yes, please explain ____

11. Please designate a cessation champion for yourself. Someone in your life who supports your decision and will support you as you face this challenge. This person must agree to be contacted, if necessary, following the program completion.

    a. Name:____

    b. Telephone number: ___________________________ Email:____________________________

This is a voluntary program. I understand this is a one year, once in a lifetime benefit, and I must be covered by the MUS Health plan to qualify. Expenses that occur prior to approval or after one year will not be reimbursed. This benefit may be terminated if I do not comply with the program requirements. By authorizing this form, I agree to program management coordination for qualifying expenses. I authorize the MT Tobacco Quit Line to provide verification of my participation in health coaching to the MUS Benefits office. *This information will only include the number of times I contact the Quit Line per month.* I may revoke this authorization at any time. I agree to be contacted to provide more information following program completion for program evaluation purposes. I understand that all my personal information will be kept confidential.

Signature: ____ date: __________________________

Please return this form to MUS Benefits office: 2500 Broadway, Helena, Mt 59601, or fax to 406-444-0222. Upon receipt of this application/contract, you will be contacted within 14 business days to discuss program options and answer questions.