2024 Working Spouse Affidavit

Our records show you have enrolled a spouse under the Lennox medical plan. If your spouse is eligible to participate under another company's health insurance plan and you elect to enroll him/her as a dependent in the Lennox medical plan, you will pay an **additional $100 per month** for your spouse's coverage.

This additional charge will only be applied if your spouse is eligible for health insurance at their job, but he/she declines or elects that coverage, and you enroll your spouse in the Lennox medical plan.

Please complete this form and return it to BenefitSource. Surcharges will be stopped as soon as administratively possible on a **going forward basis** once the signed affidavit is received by BenefitSource.

Fax to: 1-866-295-1706, or **upload it to your Employee Profile on BenefitSource.**

For questions or further assistance, contact a BenefitSource representative at **(800) 284-4549**.

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1) Is your spouse enrolled in the Lennox medical benefits, but does not work?

____ Yes ____No

2) Is your spouse working and eligible to receive medical benefits with his/her employer?

____ Yes ____No

If you answered **"Yes"**, to **question #2**, you will be charged an **additional premium of $100/month**. For information regarding the working spouse surcharge, please visit Lennox Benefits at www.liibenefits.com. LII takes voluntary disclosures seriously and retains the right to verify the truthfulness of your response.

Certification

I understand that my benefit elections are typically in effect for one full benefit plan year and cannot be changed until the next enrollment period, unless I have a qualified family status change. I also understand that if I have a qualified family status change, I have 31 days from the date of the qualified family status change to make changes to my benefit plans, and that I may be required to furnish proof of the qualified family status change or be asked to furnish evidence of insurability for myself or my eligible dependents.

The Lennox Code of Conduct "calls for nothing less than honesty and integrity in everything we do." **I certify the information I have provided is accurate and complete.** Further, I understand that providing false or fraudulent information is cause for disciplinary action, including retroactive loss of benefits coverage or termination of employment. In the event of retroactive loss of benefits coverage, payment for all claims incurred during the period of ineligibility will be my sole responsibility.

I authorize payroll deductions, if required, for my contribution in the cost of the coverage I have selected.

Employee's Name Printed _____ **Lennox Employee ID Number** _____

Signature _____ **Date** _____