2024 CHICAGO TUBE AND IRON COMPANY
EMPLOYEE BENEFIT PLAN
NON-TOBACCO DISCOUNT AFFIDAVIT

To apply for the non-smoker discount to your medical insurance premium, please complete this form and send **via email** to humanresources@chicagotube.com. All changes will be made prospective and there will be no refunds on premiums already paid. **Submittal of this form is required in order to qualify for the non-tobacco discounted rates in effect beginning January 1, 2024.**

NAME:	**DIVISION:**

Chicago Tube and Iron Company provides all non-tobacco users with a 30% discount to their monthly medical insurance premium rates. Tobacco includes all forms (smokeless, cigarette or cigar). Qualification for the discount is based on your current tobacco use as of this year's open enrollment period.

Please Note: If your spouse is also insured under the Plan, he/she must also be a non-tobacco user in order for the employee to receive the discount. To apply for the discount, both you and your spouse must complete and submit a signed non-smoker discount affidavit form.

You may request a change in your smoking status outside of Open Enrollment. You will be required to provide certification (such as completion of a smoking cessation program, etc.) with an updated affidavit form. The change to your smoking status will be limited to qualification or loss of eligibility for the discounted rate. This change does not create a qualifying event to allow other changes to your plan. The change will be limited to the effective date filed with no retroactive premium adjustment.

Please note: only non-tobacco users will qualify for the discounted monthly rates.

By your signature on this affidavit, you are certifying that you are not a tobacco user and have not used tobacco for more than three (3) months.

I acknowledge and understand that CTI will comply with the HIPAA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize CTI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false Information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein will result in the loss of coverage.

EMPLOYEE SIGNATURE _____ DATE SIGNED _____

SPOUSE SIGNATURE (IF INSURED) _____ DATE SIGNED _____