J M SMITH
CORPORATION

2024 J M Smith Corporation Working Spouse Affidavit

J M Smith employees who are electing to obtain medical coverage for their spouse under one of the employee health plans are required to provide information on whether or not their spouse has access to other medical coverage through his or her own employer. **If you are enrolling your spouse for coverage in the J M Smith Health Plan for 2024, you may be subject to an additional monthly surcharge of $50.00 for Medical coverage. This amount will be deducted pre-tax from your pay as part of your bi-weekly health care premium.**

Please print
Name of Employee: _____

Please print
Name of Spouse: _____

Important: Please ensure this form is fully completed.
Your response, or lack of response, will impact your spouse's health care coverage.

Spouse Employment Information

To determine if your spouse is eligible or if you will be subject to a $50 per month surcharge for enrolling your spouse in the Medical plan, answer the following questions:

1. Is your spouse currently employed? □ Yes □ No

   1a. If yes, is your spouse self-employed or works part time? □ Self-employed □ Part-time

2. Is your spouse eligible for a Medical plan through his/her employer? □ Yes □ No

If you answer **Yes** to both of the questions above, coverage is available to your spouse through the J M Smith Health Plan for a monthly surcharge fee of $50 in addition to the current monthly applicable premium.

If you answer **Yes** to the first question and **No** to the second question, you must provide a letter (on company letterhead) from your spouse's employer stating health insurance coverage is not available to him/her.

If you answered **No** to the first question, you will **not** be charged an additional $50 monthly surcharge to cover your spouse under the J M Smith Health Plan.

If you have additional questions about this provision, you may contact Corporate Benefits, Pam Watson at 864.542.9419, extension 5483.

By signing this affidavit, you are certifying that you have answered the questions regarding your spouse's access to medical coverage honestly and completely.

_____ _____

Employee Signature Date

PLEASE RETURN COMPLETED REQUEST TO PAM WATSON, NANCY CLEMENTS, OR TO YOUR DIVISION HR OFFICE

Office Use only / Date Received _____