



Dear employee:

Trane offers both medical plan benefits and the LifeSteps program to all U.S. employees and their eligible dependents. If you choose not to enroll in the medical plan, you can still participate in the LifeSteps program.

IMPORTANT: If you, your spouse, your same sex domestic partner or any adult dependent who is eligible to participate in Trane's medical plan is not enrolled in the medical plan, but would like to use the LifeSteps program's services (such as health coaching), you must complete this form and return it to your local benefits representative.

If you are enrolled in Trane's medical plan, you do not need to complete this form. Only those individuals who are not enrolled in the medical plan need to sign this form in order to participate in LifeSteps. For example, if you, as an employee, are enrolled in the medical plan, but your spouse is not, only your spouse would need to sign the consent form.

Please read carefully before signing:

I understand that if I opt out of coverage under Trane's medical plan, I will still be eligible to use certain LifeSteps' services, including the health coaching service provided by Health Dialog. If I choose to use LifeSteps' services, I understand and agree that any personal health information provided to Health Dialog may be aggregated and used by Health Dialog under the same conditions as personal health information that is provided to Health Dialog by those individuals who do participate in the Trane medical plan.

Such personal health information is protected by federal and state privacy laws and will not be disclosed to Trane except under limited circumstances as authorized by law for the administration of Trane's group health plans. I have read and agree with the foregoing condition to my use of LifeSteps' health services should I opt out of the Trane group medical plan.

Required fields to identify employee:

Name of employee and SSN (please print)

Business location (city and state)

Please complete these fields as appropriate:

Name of employee, only if opt out of medical coverage (please print clearly)

Signature of employee

Date of birth and self-service ID

Name of spouse (please print clearly)

Signature of spouse

Date of birth

Name of same sex domestic partner if eligible (please print clearly)

Signature of same sex domestic partner if eligible

Date of birth

Name of adult dependent (please print clearly)

Signature of adult dependent

Date of birth

*** Please return this signed consent form to your local benefit representative ***