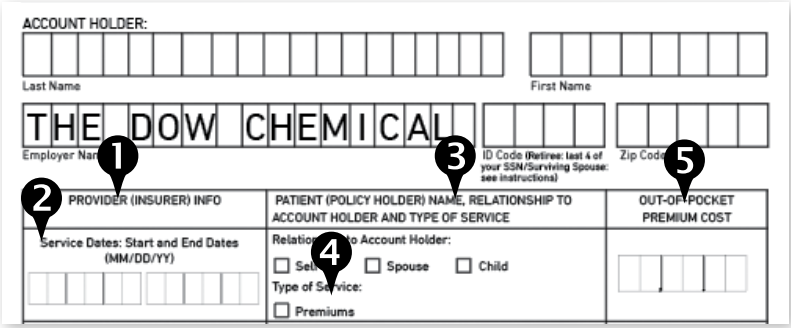
THE DOW CHEMICAL COMPANY RETIREMENT HEALTH CARE ASSISTANCE PLAN (RHCAP) CLAIM FORM

Claim Filing Options:

- File claim online for faster processing: Log in to your account at wageworks.com to submit your claim electronically.
- File claim via fax or mail: A completed form may be printed and faxed or mailed with documentation. Fax: 877-353-9236, US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

- Complete ALL account holder information.
- Please attach proof of each health insurance coverage and premium payment you list below.
- Use your documentation to complete each section of the form, including the following:



1. Provider Name (Insurance Company Name)
2. Service Date(s) (Coverage Date(s))
3. Patient (Policy Holder) Name and Relationship to Account Holder
4. Type of Service (Premiums)
5. Patient (Policy Holder) Responsibility

Tips For Claim Submission

- An eligible dependent is defined as a Spouse of Record or Dependent Child.
- Only submit claims for post tax medical insurance premiums. Dental, vision, pre-tax premiums and medical expenses are not eligible for reimbursement. See Summary Plan Description for more information.
- If you are a surviving spouse, please use the last 4 digits of your Dow EEID as the ID Code on the claim form. If you are unsure of your Dow EEID, please contact the Dow Retiree Service Center at 800-344-0661.
- Proof of Coverage is documentation from the insurance carrier:
  - Policy Statement
  - Receipt
  - Invoice
  - Coupon Book
  - Letter from the Insurance Carrier
  - Print out from the website confirming coverage
  - Paystub showing insurance premium deduction
- Proof of payment can be any of the following (only one is required):
  - Bank statement or credit card statement that shows your payment
  - Participant Name and the Banking Institution must be visible
  - Health Plan statement showing that payment has been posted
  - Screen print-out from banking site showing that check has been cleared
  - Proof that the check is a cancelled check (payment amount & bank stamp must be visible)
  - Proof that payment was deducted from a paycheck
  - Proof from the insurance carrier that payment was received
- You may include premiums from two different insurance companies. Eligible RHCAP claims must be submitted in the same calendar year of coverage or by December 31 of the following year (i.e., January 2018 monthly medical premium claims may be filed in 2018 or by the end of December 31, 2019).
- Ensure that the documentation is legible.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via US Mail.

THE DOW CHEMICAL COMPANY RETIREMENT HEALTH CARE ASSISTANCE PLAN (RHCAP) CLAIM FORM

- File claim online for faster processing. Log in to your account at wageworks.com to file your claim electronically and upload your documentation.
- File claim via fax or mail: Claim forms may also be filed either via fax or US Mail and sent to the following locations:
  Fax: 877-353-9236,
  US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

  Claims will be processed for monthly reimbursement. You may check the status of your claim by logging in to your account at WageWorks.

ACCOUNT HOLDER:

Last Name

First Name

THE DOW CHEMICAL

Employer Name

ID Code (Retiree: last 4 of your SSN/Surviving Spouse: see instructions)

Zip Code

PROVIDER (INSURER) INFO	PATIENT (POLICY HOLDER) NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET PREMIUM COST
Service Dates: Start and End Dates (MM/DD/YY)	Patient (Policy Holder) Name: Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Child Type of Service: ☐ Premiums	
Service Dates: Start and End Dates (MM/DD/YY)	Patient (Policy Holder) Name: Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Child Type of Service: ☐ Premiums	
Service Dates: Start and End Dates (MM/DD/YY)	Patient (Policy Holder) Name: Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Child Type of Service: ☐ Premiums	

More expenses? Please complete another form.

CLAIM FORM TOTAL:

THE DOW CHEMICAL COMPANY RETIREMENT HEALTH CARE ASSISTANCE PLAN (RHCAP) CLAIM FORM

I certify that the medical premiums listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. I (or my Spouse of Record or Dependent Child) have not, or am not, claiming the premiums for tax credit under the Internal Revenue Code (" IRC"), and further, the premiums have not been paid using pre-tax dollars under the auspices of the IRC. If I am a Surviving Spouse, I have not remarried. Bills, statements, or other proof of these medical premium payments are attached.

CERTIFICATION AND AUTHORIZATION:
By submitting this claim form, I certify that:

1. The information on this page is accurate and complete.
2. I am requesting reimbursement for my own personal expenses.
3. These services have already been purchased.
4. I have not and will not seek reimbursement of this expense from any other plan or party.
5. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter username and password or click on Employee Registration link).
6. I understand that reimbursement will be processed as soon as administratively possible.