The Dow Chemical Company
Authorized Representative Form for Benefit Plans and Payroll Matters

This form allows you (a "Principal") to (1) authorize an Administrator to disclose to an Authorized Representative the information described on this form pertaining to your benefits and rights under the Plans with respect to which you are a Principal on or after the date of the authorization; (2) authorize the Authorized Representative to act on your behalf with respect to claims and appeals; and (3) authorize an Administrator to disclose to an Authorized Representative information pertaining to Payroll Matters. ***You must also complete and sign the attached HIPAA Authorization Form.*** If you fail to do so, this authorization will not be effective. The HIPAA authorization is required because the authorization may authorize the release of medical information to the Authorized Representative with respect to Medical Plans.

- A "Principal" includes a participant, dependent, alternate payee, or other person who is enrolled in or has a benefit or right under a Plan (including the beneficiary of a deceased Plan participant), or a person who receives or received payments for services performed as an employee for Dow directly from Dow's payroll department.
- An "Administrator" includes:
    - Dow and any representative of Dow (including the HR and Retiree Service Centers);
    - the plan administrator, claims administrator, appeals administrator, or other plan fiduciary of a Plan, and any delegee of such person or entity; and
    - any third-party administrator or recordkeeper of a Plan or third-party payroll vendor.
- An "Authorized Representative" is the individual you designate below on page 3.
- A "Plan" is a Qualified Retirement Plan, Non-Qualified Retirement Plan, Medical Plan, or Non-Medical Welfare Plan sponsored by Dow and listed in the Appendix.
- "Dow" includes The Dow Chemical Company or a subsidiary of The Dow Chemical Company.
- "Payroll Matters" includes information about compensation paid to employees (*e.g.*, wages, salaries, and bonuses), direct deposit, tax withholdings, contributions to Plans, deductions for Plan benefits, and Form W2.

This form is NOT a power of attorney and does NOT give the Authorized Representative express or implied authority to make or change: medical care decisions, benefit elections, enrollment decisions, beneficiary designations, contribution levels, investment decisions, employee contact information, direct deposit information, wire transfer instructions, online account login information, allowances for purposes of income tax withholding (*e.g.*, Form W-4 for federal income tax) , or any other decisions that affect the investment, amount, or payment of your benefit, the exercise of your rights under a Plan (except with respect to your claim or appeal under a Plan), or your payments for services performed by Dow. If you wish to give an individual this authority, you must establish a power of attorney or living will. Please discuss this with your attorney.

In addition, this form ***cannot*** be used for qualified domestic relations orders ("QDROs"). Please contact the plan administrator of your Plan for a copy of any applicable QDRO procedures.

Note: In many cases, third-party administrators or recordkeepers ("TPAs") assist the plan administrator in administering a Plan, and a third-party payroll vendor may assist with Payroll Matters (each a "Third Party"). For example, Fidelity assists in administering The Dow Chemical Company Employees' Savings Plan and Dow's Elective Deferral Plans. Medical Plan benefit claims and appeals are typically decided by a TPA. The Third Party may require you to provide a different authorization or consent in a form satisfactory to the Third Party. ***You are responsible for providing a copy of this form, including the HIPAA Authorization Form (if applicable), to the Third Party and for providing any additional authorization or consent required by the Third Party.*** *See your summary plan description for the TPA's contact information.*

AUTHORIZATION

By my signature below I, the Principal identified on page 3 below, hereby:

1. Authorize the Administrators to disclose to my Authorized Representative information pertaining to my benefits and rights under the Plans with respect to which I am a Principal on or after the date of this authorization. Such information includes, but is not limited to the following:
   - the name of the Plans, and if applicable, benefit options in which I am enrolled;
   - the names of my beneficiaries and/or enrolled dependents;
   - information about vesting of my benefits and/or eligibility for benefits;
   - distribution options available to me;
   - contact information for plan administrators, third-party administrators, and record-keepers;
   - my benefit amount or account balance;
   - my pension benefit statements;
   - a copy of current plan documents, summary plan descriptions, and annual reports;* and
   - information about submitting a benefit or eligibility claim.
2. Authorize my Authorized Representative, in accordance with 29 CFR § 2560.503-1(b)(4), to act on my behalf to:
   - pursue an eligibility or benefit claim, appeal an adverse eligibility or benefit determination;
   - exercise all rights and receive all communications and notices connected to my claim or appeal; and
   - receive reasonable access to, and copies of, all documents records, and other information relevant to my claim or appeal (as determined by the applicable claims administrator or appeals administrator).
3. Authorize the Administrators to disclose to my Authorized Representative information pertaining to Payroll Matters (defined above).

This authorization will remain in effect from the date signed until I revoke it, as described below.

I understand that:

- If I wish to revoke this authorization, I must do so in writing by mailing to Dow North America Benefits, P.O. Box 981901, El Paso, TX 79998 or faxing to 1-866-579-6695. I understand that such revocation will become effective as soon as administratively practicable after it is received by Dow North America Benefits.
- If I revoke this authorization, my revocation will not have any retroactive effect (*i.e.*, will not nullify any authority the Authorized Representative had to receive information prior to the revocation).
- Information disclosed to the Authorized Representative pursuant to this authorization may be subject to re-disclosure by the Authorized Representative.
- This authorization is not a power of attorney, and cannot be used by the Authorized Representative to make a decision or change an election with respect to any of my benefits under the Plans selected above, except insofar as this authorization authorizes the Authorized Representative to act on my behalf with respect to claims and appeals.
- I understand that signing this form is voluntary and that my failure to sign will not affect my eligibility for benefits under the Plans.
- I understand that I must complete and sign the attached HIPAA Authorization Form and that if I fail to do so, this authorization will not be effective. I understand that the HIPAA authorization is required because this authorization applies to Medical Plans, and may authorize the release of medical information to my Authorized Representative.

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* *Note: A reasonable fee may be charged for printed copies of plan documents and summary plan descriptions.*

Please sign and notarize. Provide a copy to Dow North America Benefits by mailing to P.O. Box 981901, El Paso, TX 79998 or faxing to 1-866-579-6695. Keep the original for your records. ***You are responsible for providing a copy of this form, including the HIPAA Authorization Form (if applicable), to the Third Party and for providing any additional authorization or consent required by the Third Party.*** See your summary plan description for your TPA's contact information.

AUTHORIZED REPRESENTATIVE INFORMATION

Name†: Relationship to Principal†:

Phone†: E-Mail:

Address:

YOUR INFORMATION AND SIGNATURE

Your Name†: Phone†:

Date of Birth†: Dow ID No. †: E-Mail:

Address:

Signature†: Date†:

Personal Representative: If a personal representative (*e.g.*, parent or guardian of a minor or incapacitated person, or executor of an estate) is signing on behalf of the Principal, provide the following information for the personal representative:

Name: Relationship to Principal:

NOTARIAL CERTIFICATE‡

STATE OF _____)

) ss.

COUNTY OF _____)

On this _____ day of , 20___, before me, a Notary Public, personally appeared the above-named person who acknowledged signing the above and foregoing instrument as a free act and deed.

_____

(Stamp) Notary Public

† *Indicates Required Field*

‡ Note: If this certificate does not comply with the notarization rules of your jurisdiction or you need additional space, please attach a notarial certificate, write "See attached notarial certificate" above, and on the certificate include (1) the date, (2) document description, and (3) the number of pages. For example, "This certificate is attached to page ___ of the Authorized Representative Form, dated _____ , consisting of __ pages and signed by _____."

APPENDIX

The following is a non-exhaustive list of Plans (as defined above) as of October 1, 2017. ***Dow reserves the right to amend, modify, or terminate the Plans (and any of the plans offered under the Plans) at any time in its sole discretion.***

Qualified Retirement Plans

- Dow Employees' Pension Plan
    - Dow Corning Corporation Employees' Retirement Plan
    - Rohm and Haas Company Retirement Plan
- The Dow Chemical Company Employees' Savings Plan
- Union Carbide Employees' Pension Plan

Non-Qualified Retirement Plans

- Dow Corning Supplemental Savings Plan
- Dow Corning Corporation 415 Excess Plan
- Dow Corning Corporation Supplemental Retirement Plan
- Rohm and Haas Company Non-Qualified Retirement Plan
- Rohm and Haas Company Non-Qualified Savings Plan (Pre-2005)
- Rohm and Haas Company 2005 Non-Qualified Savings Plan
- The Dow Chemical Company Elective Deferral Plan (Pre-2005)
- The Dow Chemical Company Elective Deferral Plan (Post-2004)
- The Dow Chemical Company Executives' Supplemental Retirement Plan- Supplemental Benefits
- The Dow Chemical Company Executives' Supplemental Retirement Plan - Restricted & Cadre Benefits
- The Union Carbide Executives' Supplemental Retirement Plan

Medical Plans

- Rohm and Haas Company Health and Welfare Plan
- The Dow Chemical Company Dental Assistance Program
- The Dow Chemical Company Executive Physical Examination Program
- The Dow Chemical Company Health Care Reimbursement Account (a component of The Dow Chemical Company Flexible Spending Plan)
- The Dow Chemical Company Insured Health Program
- The Dow Chemical Company Long Term Care Program
- The Dow Chemical Company Medical Care Program
- The Dow Chemical Company Retiree Medical Care Program
- The Dow Chemical Company Retirement Health Care Assistance Plan
- Union Carbide Corporation Retiree Insured Health Program
- Union Carbide Corporation Retiree Medical Care Program

Non-Medical Welfare Plans

- The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Program
- The Dow Chemical Company COLI Incentive Program
- The Dow Chemical Company Dependent Day Care Reimbursement Account (a component of The Dow Chemical Company Flexible Spending Plan)
- The Dow Chemical Company Employee Paid and Dependent Life Insurance Program
- The Dow Chemical Company Flexible Spending Plan (excluding the Health Care Reimbursement Account component)
- The Dow Chemical Company Group Legal Plan
- The Dow Chemical Company Group Life Insurance Program
- The Dow Chemical Company Long Term Disability Program (applicable to those who were actively at work on or after January 1, 2008)
- The Dow Chemical Company Long Term Disability Program (applicable to those who were fully disabled prior to January 1, 2008)
- The Dow Chemical Company Michigan Contract Disability Plan
- The Dow Chemical Company Texas Operations Hourly Total and Permanent Disability Plan
- The Dow Chemical Company Transition Payment Program
- The Dow Chemical Company Voluntary Group Accident Insurance Plan
- Union Carbide Corporation Long Term Disability Plan
- Union Carbide Corporation Transition Payment Program

HIPAA Authorization Form for Medical Plans

By my signature below, I hereby authorize the Administrators to disclose the health information described below, which may include my name, address, account number, and other identifiers, pertaining to my benefits and rights under the Medical Plans (defined below) to the Authorized Representative, to assist me in exercising my rights under the Medical Plans and receiving information about the Medical Plans.

- A "Principal" includes a participant, dependent, alternate payee, or other person who is enrolled in or has a benefit or right under a Medical Plan (including the beneficiary of a deceased Medical Plan participant).
- An "Administrator" includes:
  - Dow and any representative of Dow (including the HR and Retiree Service Centers);
  - the plan administrator, claims administrator, appeals administrator, or other plan fiduciary of a Medical Plan, and any delegee of such person or entity; and
  - any third-party administrator or recordkeeper of a Medical Plan.
- An "Authorized Representative" is the individual you designate below on page 2.
- A "Medical Plan" is a plan sponsored by Dow that provides medical, dental, long term care, or physical examination benefits or that provides for the payment of medical care. See the Appendix to the Authorized Representative Form for a list of Medical Plans.
- "Dow" includes The Dow Chemical Company or a subsidiary of The Dow Chemical Company.

Information:

I authorize the Administrator to disclose to the Authorized Representative information pertaining to my benefits and rights under the Medical Plans (defined above), including but not limited to:

- the name of the Medical Plans, and if applicable, benefit options in which I am enrolled;
- the names of my beneficiaries and/or enrolled dependents;
- information about eligibility for my benefits;
- contact information for plan administrators, third-party administrators, and record-keepers;
- my benefit amount or account balance;
- a copy of current plan documents, summary plan descriptions, and annual reports;* and
- information about submitting a benefit or eligibility claim.

In accordance with 29 CFR § 2560.503-1(b)(4), I authorize the Administrator to disclose to the Authorized Representative information reasonably necessary to act on my behalf to:

- pursue an eligibility or benefit claim, appeal an adverse eligibility or benefit determination;
- exercise all rights and receive all communications and notices connected to my claim or appeal; and
- receive reasonable access to, and copies of, all documents records, and other information relevant to my claim or appeal (as determined by the applicable claims administrator or appeals administrator).

Duration:

This authorization will remain in effect from the date signed until (a) the earlier of my death, termination of the Plan, or the date I cease to be a Principal with respect to the Plans, or (b) if earlier, I revoke it, as described below.

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* *Note: A reasonable fee may be charged for printed copies of plan documents and summary plan descriptions.*

I understand that:

- If I wish to revoke this authorization, I must do so in writing by mailing to Dow North America Benefits, P.O. Box 981901, El Paso, TX 79998 or faxing to 1-866-579-6695. I understand that such revocation will become effective as soon as administratively practicable after it is received by Dow North America Benefits.
- If I revoke this authorization, my revocation will not have any retroactive effect (*i.e.*, will not nullify any authority the Authorized Representative had to receive information prior to the revocation).
- Information disclosed to the Authorized Representative pursuant to this authorization may be subject to re-disclosure by the Authorized Representative and no longer be protected by federal privacy regulations. State privacy laws may apply.
- I understand that signing this form is voluntary and that my failure to sign will not affect my eligibility for benefits under the Medical Plans.

Please sign and provide a copy to Dow North America Benefits by mailing to P.O. Box 981901, El Paso, TX 79998 or faxing to 1-866-579-6695. Keep the original for your records. ***You are responsible for providing a copy of the Authorized Representative Form, including this form (if applicable), to the Third Party and for providing any additional authorization or consent required by the Third Party.*** See your summary plan description for your TPA's contact information.

AUTHORIZED REPRESENTATIVE INFORMATION

Name†: Relationship to Principal†:

Phone†: E-Mail:

Address:

YOUR INFORMATION AND SIGNATURE

Your Name†: Phone†:

Date of Birth†: Dow ID No.*: E-Mail:

Address:

Signature†: Date†:

Personal Representative: If a personal representative (*e.g.*, parent or guardian of a minor or incapacitated person, or executor of an estate) is signing on behalf of the Principal, provide the following information for the personal representative:

Name: Relationship to Principal:

† *Indicates Required Field*