# The Dow Chemical Company
# Health & Welfare Plan Inquiry/Claim Form
# Current and Former Employees

If you are a current or former employee of The Dow Chemical Company ("Dow") or any of its subsidiaries, and you wish to submit a claim for eligibility to participate in a Dow, Dow Corning, Union Carbide, or Rohm and Haas health or welfare benefit plan, or a claim for eligibility or benefits under certain other welfare plans, please complete this form and return it to the address at the bottom of the page. In order to expedite resolution of your claim/inquiry, please fill out as much of the form as you can and attach all documentation you have that supports your claim/inquiry. If you would like additional information about the plan's claims process, including applicable deadlines, please consult the applicable plan's Summary Plan Description ("SPD"). Current employees may access an electronic copy (which is printable) of the most current SPD by logging on to My HR Connection or requesting a copy by contacting the Dow Service Center. Former employees may request a copy of the applicable SPD by contacting the Dow Retiree Service Center at 1.833.693.6947.

Use this form if:

- □ your claim relates to eligibility for you or a dependent to enroll or participate in any Dow health or welfare plan or the date(s) on which you or a dependent became eligible or enrolled a plan.
- □ your claim relates to premium payments you may have paid or may owe in connection with your coverage under any Dow health or welfare plan.
- □ your claim involves payment of benefits under a Dow welfare plan that is not administered or insured by a third party.

Do *not* use this form if—

- □ your claim relates to coverage for particular treatment under a Dow medical plan and you are already a participant in that plan; please contact the medical plan provider for your plan.
- □ your claim relates to payment of benefits under a Dow life insurance or long-term disability plan and you are already a participant in that plan; please contact the applicable insurance provider.
- □ your claim relates to reimbursement for qualified expenses under the health savings account (HSA) or limited-purpose HSA, or dependent care savings account; please contact PayFlex.

## Instructions

- Both current and former employees of Dow, or one of its subsidiaries, should complete the "**Part A—General Information**" portion of this form.
  - If you are a current employee of Dow, or one of its subsidiaries, please complete and sign (on page 5) the "**Part B—Current Employee**" portion of this form and return it, **along with all supporting documentation,** to the address below.
  - If you are a former employee of Dow, or one of its subsidiaries, please complete and sign (on page 5) the "**Part C—Former Employee**" portion of this form and return it, **along with all supporting documentation,** to the address below.
- If you are not sure of the answer to a question, or if a question on the form does not apply to you, you may leave it blank. **However, please keep in mind that failure to provide sufficient information could result in the denial of your claim.** Accordingly, it is very important that you fill out as much of the form as possible.

## Please provide copies of any documents that support your claim or inquiry.

Supporting documentation is very important because it will help us process your claim/inquiry, so please send any documentation that you believe supports your claim/inquiry (please send photocopies as originals will not be returned.). **If you are unable to provide supporting documentation to confirm material facts regarding your claim, your claim could be denied.** Helpful documents may include, but are not limited to: letters or emails from Dow or one of its subsidiaries, welfare and benefit statements or explanation of benefits (EOBs), enrollment forms, or benefit and election confirmation notices.

After you have completed the form, please review it carefully to make sure there are no errors, and then return the completed form and copies of any supporting documents to:

**N.A. Health and Welfare Leader**
**The Dow Chemical Company**
**P.O. Box 2169**
**Midland, Michigan 48641**

# Dow Welfare Benefit Claim Form: Part A—General Information

**This is a:** (select one)

___ Claim

___ Inquiry

**This request applies to:** (check all that apply)

___ Eligibility to Participate in the Plan

___ Dependent Eligibility

___ Termination for Nonpayment of Benefit Contributions or Premiums

___ Medicare Reimbursement

___ Health Reimbursement Account

___ COBRA Continuation Coverage

___ Life Insurance

___ Other: _____

**Denial of benefits**

Please confirm if you attempted to receive health care services for yourself or your dependent and those services were not provided or reimbursed.

___ Yes
___ No

# Dow Welfare Benefit Claim Form: Part B—Current Employee

Please fill out the three boxes listed below and then sign and date this form (located on page 5.) **Please provide copies of any documents you have that support your claim.** If you do not fill out the form completely, or if you fail to provide supporting documentation for you claim, your claim may be denied. **(Please do not send original documents as they will not be returned to you.)**

Current Employee Information:

| |
|---|
| Name:<br><br>Dow Employee Identification Number: |
| Please indicate the plan(s) in which you believe you have a benefit: |
| Please describe the specific reasons you believe your benefit is incorrect (attach additional sheet(s) as necessary): |
| Please provide any other additional information you believe is helpful to your claim or inquiry (attach additional sheet(s) as necessary): |

# Dow Welfare Benefit Claim Form: Part C—Former Employee

- Please fill out the form below. If you do not know exact dates, please provide approximate dates. **Please provide copies of any documents you have that support your claim.** If you do not fill out the form completely, or if you fail to provide supporting documentation for your claim, your claim may be denied. **(Please do not send original documents as they will not be returned to you.)**

- If you are the survivor of a deceased former employee, please fill out this form with the former employee's information and then include your current address and phone number at the bottom of the form. **Please provide copies of any documents you have that support your claim.**

Former Employee Personal Information

| | |
|---|---|
| Name: (Please include your current name and any former names.) | |
| Address: | City: |
| | State & Zip: |
| Date of Birth: | Cell Phone Number |
| Home Phone Number: | Work Phone Number: |
| Spouse's Name (if married): | |
| Spouse's Date of Birth: | |

Former Employee Work Record

Please indicate the plan(s) in which you believe you have a benefit by checking the applicable box(es) below (check all that apply):

☐ Dow Chemical Company Retiree Medical Care Program
☐ Union Carbide Corporation Retiree Medical Care Program
☐ Rohm and Haas Retiree Medical Care Program
☐ Other: _____

| |
|---|
| Name of Former Employer (*e.g.*, Dow, Dow Corning, Union Carbide, Rohm and Haas, etc.): |
| Work Location(s) and Date(s) at each Location: |
| Division(s) or Departments) Worked: |
| Hire Date(s) (month, day, year): |
| Termination Date(s) (month, day, year): |
| Title & Position When Hired: |
| Title & Position At Termination: |
| Name of Last Supervisor: |
| Did you ever have a "Break-in-Service" during your employment, e.g., layoff, maternity leave, etc.? If yes, please provide details. |
| What is your claim or inquiry? (attach additional sheet(s) as necessary) |
| If you have been provided a benefit amount, please describe the specific reasons you believe your benefit is incorrect (attach additional sheet(s) as necessary): |
| Please provide any other additional information you believe is helpful to your claim or inquiry (attach additional sheet(s) as necessary): |

| Please indicate if you were (check all that apply): |
|---|
| ☐ Full-Time |
| ☐ Part-Time |
| ☐ Seasonal |
| ☐ Temporary |
| ☐ Represented by a union |
| ☐ Salaried |

**ONLY COMPLETE THE BELOW SECTION IF YOU ARE A SURVIVOR OF A FORMER EMPLOYEE**

| Survivor Name: | |
|---|---|
| Survivor Address: | City: |
| | State & Zip: |

**ACKNOWLEDGMENT AND SIGNATURE:**

**To the best of my knowledge, the information I provided above is complete and accurate. I understand that any rights under the plan are governed by the claims procedures of the plan.**

_____ _____

(Signature) (Date)