TEAMCARE – A CENTRAL STATES HEALTH PLAN QUALIFIED SAME-SEX DOMESTIC PARTNERSHIP AFFIDAVIT

The undersigned TeamCare Participant and same-sex partner, by this affidavit, assert that the Participant's same-sex partner qualifies for Plan coverage under the Qualified Same-Sex Domestic Partner amendments to the Plan recently adopted by the Trustees and described in the Summary Plan Description, effective January 1, 2014. The Summary Plan Description describes a Qualified Same-Sex Domestic Partner to be "an individual who shares a stable (but non-Spousal) domestic partner same-sex relationship with a Participant". A Qualified Same-Sex Domestic Partnership may be established in a state or other jurisdiction which recognizes same-sex domestic partnerships (but not same-sex marriages) "provided that the relationship qualifies for such legal recognition or status under the laws of the state or jurisdiction of the Participant's residence and a written record or registry documenting the legal qualification of the same-sex domestic partnership is presented to TeamCare".

The Summary Plan Description further states that a Qualified Same-Sex Domestic Partnership may also be established in a state or other jurisdiction that recognizes neither same-sex marriage or same-sex domestic partnerships if "the domestic partners have been in an exclusive and committed relationship for at least 12 months in the same principal residence, intend to remain in the relationship permanently, are jointly responsible for each other's living expenses and welfare, have not entered the relationship solely for the purpose of securing benefits coverage".

The Summary Plan Description, regarding when coverage begins for a Qualified Same-Sex Domestic Partnership states, "Generally, coverage for your enrolled qualified same-sex domestic partner begins when your coverage begins. Documentation supporting the establishment of a Qualified Same-Sex Domestic Partnership will be required before coverage is granted."

The undersigned Participant and same-sex partner acknowledge that, in order for the Participant's same-sex partner to be eligible for coverage under the Plan, the Participant and the Participant's same-sex partner must have entered into a Qualified Same-Sex Domestic Partnership as described above. Thus, pursuant to the above requirements, the undersigned Participant and the Participant's same-sex partner jointly make this affidavit under oath, having both been duly sworn, and state the facts contained herein are true upon the personal knowledge of each undersigned Affiant.

QUESTIONS TO BE ANSWERED

1. The undersigned Participant and same-sex partner are residents of the state of _____ which recognizes same-sex domestic partnerships and as such the parties qualify for legal recognition or status under state law and a written record or registry documenting the legal qualifications of the same-sex domestic partnership is presented to TeamCare with this affidavit? If this question is answered "yes" and the requested information is provided, it is not necessary to respond to questions 2-5. ☐YES ☐NO
2. The undersigned Participant and same-sex partner are residents of the State of _____ and said state does not allow same-sex marriages or domestic partner relationships? ☐YES ☐NO
3. The undersigned Participant and same-sex partner state that they have established an exclusive and committed relationship for at least 12 months in the same principal residence? ☐YES ☐NO
4. The undersigned Participant and same-sex partner intend to remain in the relationship permanently? ☐YES ☐NO
5. The undersigned Participant and same-sex partner state that they share joint responsibility for each other's living expenses and welfare? ☐YES ☐NO
6. The undersigned Participant and same-sex partner state that they have not entered into this Qualified Same-Sex Domestic Partnership solely for the purpose of securing benefits coverage under the Plan? ☐YES ☐NO

We the undersigned acknowledge that all of the statements made herein are true and accurate, and if the same-sex partner of the Participant receives coverage under the Plan, pursuant to the representations made in this affidavit, each agree and recognize that § 8.04 of the Central States Health and Welfare Plan Document states, "Any misrepresentation in any claim or document submitted by a claimant to the Fund shall constitute grounds for rejection of the claim, for the denial of any requested benefits, and for the recovery by the Fund of all benefit payments made in reliance upon said misrepresentation."

If the participant and same-sex partner have answered questions 2 and 5 affirmatively, to establish that they are eligible for coverage under the Plan, before coverage is granted, the Summary Plan Description also requires the parties to present documentation as follows: A deed or other documentation (current within last 12 months) showing that the partners are joint owners of a residence, or the partners' current lease showing they are joint tenants on the lease; or If neither item is available or applicable, the partners submit a current copy of two items from the following list: a joint bank statement or credit card bill of the partners from within the last 12 months; a loan note or payment coupon showing the partners are joint obligators on a loan; utility or telephone bills from within the last 12 months showing the partners have common household and shared household expenses; other documents showing the partners have common and shared household expenses; executed wills naming each

partners as executor and/or beneficiary of the other; grants of mutual durable powers of attorney by each partner to the other; documentation signed by each partner conferring upon each other authority to make health care decisions under a health care power of attorney; documentation designating each partner as a beneficiary under the other's retirement benefits plan or account.

The undersigned Participant and same-sex partner each agree and acknowledge that coverage under the Plan for the same-sex partner terminates when the Participant's coverage ends: when the parties no longer meet the requirements of a Qualified Same-Sex Domestic Partnership; or when the parties have legally recognized the termination of the relationship. Either the Participant or the Participants' same-sex partner then must notify TeamCare within 60 days of the end of the Qualified Same-Sex Domestic Partnership. The parties also agree and understand that failure to notify TeamCare of the termination of the Qualified Same-Sex Domestic Partnership may result in the imposition of an overpayment for benefits paid by TeamCare for a same-sex partner whose coverage has terminated, and that said overpayment may be asserted by TeamCare against the Participant and/or the same-sex partner.

Further affiant sayeth not.

Participant: _____ Member ID: _____

Subscribed and sworn to before me, A Notary Public, this day of

20 ____. _____ Notary Public

Partner: _____

Subscribed and sworn to before me, A Notary Public, this day of

20 ____. _____ Notary Public

Please note that TeamCare may require additional documentation before claims can be processed. If you have any questions regarding the enrollment process, please call our Participant Services Department at 1-800-323-5000.

Please mail to: TeamCare
A Central States Health Plan
PO Box 5112
Des Plaines, IL 60017-5112

Or fax to: (847) 518-9779