Employee Health Insurance Dependent Coverage Agreement & Eligibility Certification

Employee Name (Print Clearly): _____

I, the above-named employee of Hill Laboratories, understand that I am electing or continuing health insurance coverage for myself and any listed dependents under the Company's group health plan. By signing this Agreement, I certify the following and agree to comply with all terms as a condition of coverage:

1. Certification of Eligibility

I certify that every dependent currently enrolled (or that I will enroll) meets the Plan's eligibility rules. Eligible dependents are limited to:

- My legally married spouse;
- My domestic partner (only with required proof — see Section 2 below);
- My natural, step, adopted, or foster children (or children for whom I have legal guardianship) who are under age 26.

I understand that coverage for any ineligible person is strictly prohibited.

2. Domestic Partner Coverage – Proof Requirements

Domestic partners are eligible **only** if I submit **all** of the following to HR at the time of enrollment or addition:

- A completed, signed, and notarized **Domestic Partnership Affidavit** (on the form provided by HR), sworn by both me and my partner; **AND**
- At least **two** supporting documents showing shared residence and joint financial responsibility. One document must be at least 6 months old; the second must be dated within the last 6 months. Acceptable examples include:
    - Joint residential lease or mortgage statement;
    - Joint bank or credit card account statements;
    - Joint utility bills (electric, gas, water, etc.);
    - Joint auto insurance or property insurance declarations;
    - Wills or beneficiary designations naming each other.

HR may request additional or updated proof at any time. Failure to provide or maintain valid proof will result in immediate removal of the domestic partner from coverage.

3. Ongoing Notification and Removal Obligations

I **agree** to notify Human Resources **in writing within 10 calendar days** (and provide all requested supporting evidence) of any event that makes a dependent ineligible. This includes, but is not limited to:

- Divorce, legal separation, or annulment, I must remove my ex-spouse immediately.

- Any child turning age 26, I must remove the child within 10 days of their 26th birthday (even if it occurs mid-year or mid-plan period).
- Any dependent (spouse, domestic partner, or child) becoming eligible for health insurance through their own employer, I must remove that dependent within 10 days.

I understand these removals must be processed through HR even if they occur outside open enrollment. I will not wait for the next open enrollment period.

4. Recoupment of Costs for Violations

If Hill Laboratories discovers (through audit, claim review, or any other means) that I have:

- Covered an ineligible dependent, or
- Failed to notify HR and remove a dependent within the required 10-day period,

the Company will:

1. Immediately terminate coverage for the ineligible dependent(s).
2. Recoup **100% of the premiums and any other costs** the Company paid for that ineligible coverage. Recoupment will be made from my wages, profit-sharing distribution, bonus, or any other compensation owed to me, on a reasonable repayment schedule determined by the Company (subject to applicable federal and state wage laws).
3. I authorize such deductions in advance by signing this Agreement.

I further understand that violations may result in additional disciplinary action, up to and including termination of employment, and that any suspected fraud may be reported to the appropriate authorities.

5. General Acknowledgments

- I have received and reviewed the current Summary Plan Description (SPD) and understand the full eligibility rules.
- This Agreement is a continuing obligation and applies for as long as I participate in the health plan.
- I will cooperate fully with any audit or request for documentation from HR or the insurance carrier.
- Any false statement or omission may constitute insurance fraud and can lead to immediate loss of coverage, repayment demands, and legal consequences.

I have read, understand, and voluntarily agree to all of the above terms. I acknowledge that this document supplements (and does not replace) the official Plan documents.

Employee Signature: _____ Date: _____

Officer Signature: **Date:** 3/18/2026