The Kroger Co. Health & Welfare Benefit Plan
Working Spouse/Domestic Partner Fee

The Kroger Co. Health & Welfare Benefit Plan includes a Working Spouse/Domestic Partner Fee provision. This fee applies only to Company associates whose working spouse or domestic partner is eligible for medical coverage through his or her own employer's medical plan, but wishes to enroll in the Kroger medical plan instead.

Cancel Fee Request

If the Working Spouse/Domestic Partner Fee is currently applied and your spouse or domestic partner experiences one of the following, complete this form following the instructions below.

1. Enrolls in their employer plan
2. Enrolls in their employer plan AND you want to keep Kroger's medical plan as secondary coverage
3. Terminates employment
4. Retires
5. Loses medical coverage through their employer

Instructions:

- To cancel the working spouse/domestic partner fee, this form must be completed and received by the Kroger Benefit Service Center within 31 days of the spouse's/domestic partner's effective date of coverage through his/her employer, or discontinued employment or loss of medical coverage.
- Documentation must be provided in order to cancel the working spouse/domestic partner fee. Appropriate documentation can be an enrollment confirmation statement, completed enrollment form, letter from the employer or HIPAA certificate.
- Complete, sign and forward this form, with documentation, to the Kroger Benefits Service Center. (See fax number and address at bottom of form.
- Upon approval, you will receive a Confirmation Statement showing any changes to your working spouse/domestic partner fee. If approved, the working spouse/domestic partner fee will be cancelled the first of the month following the effective the date your spouse/domestic partner became covered under his/her employer's plan, or discontinued employment, or loss of medical coverage.
- **For late requests**, the working spouse/domestic partner fee will be cancelled effective the first of the month following approval of your request.
- **This working spouse/domestic partner fee form will cancel the fee only. To cancel medical coverage for your spouse/domestic partner, you will need to complete a Qualifying Life Event on yourkrogerbenefits.com. (Documentation is required.) For more information regarding Qualifying Life Events, contact the Kroger Benefits Service Center at 877-373-3397.**

Add Fee Request

An associate of The Kroger Co. must complete this form if your spouse/domestic partner is:

1. Enrolled in Kroger medical coverage, AND
2. Employed by an employer other than The Kroger Co., AND
3. Eligible to sign-up for medical coverage through that employer, but has opted not to participate in that plan.

The working spouse/domestic partner fee will be added effective the first of the month following the date your spouse/domestic partner became eligible under his/her employer's plan.

Instructions:

- To add the working spouse/domestic partner fee, this form must be completed and submitted to the Kroger Benefits Service Center.
- Complete, sign, and forward this form to the Kroger Benefits Service Center. (See fax number and address at the bottom of the form.)
- Upon approval, you will receive a Confirmation Statement showing any changes to your working spouse/domestic partner fee. If approved, the working spouse/domestic partner fee will be added effective the first of the month following the date your spouse/domestic partner became eligible under his/her employer's plan.
- The working spouse/domestic partner fee will continue UNLESS you complete the Cancel Fee form and provide documentation that your spouse/domestic partner has enrolled in his/her employer's plan.

Please read instructions on Page 1 and complete all of the following information.

REQUEST (circle one): CANCEL FEE ADD FEE

1) Kroger Associate's Name: _____

2) Associate's Social Security Number: _____

3) Associate's Home Phone Number: _____

4) Associate's Work Phone Number: _____

5) Spouse's/Domestic Partner's Name: _____

6) Spouse's/Domestic Partner's Social Security Number: _____

7) Spouse's/Domestic Partner's Daytime Phone Number: _____

8) Spouse's/Domestic Partner's Employer:_____Date of Hire: _____

9) Spouse's/Domestic Partner's Employer's Address and Phone Number: _____

_____

10) Is your spouse/domestic partner signed up for medical coverage through his or her employer's plan?
_____Yes _____No

11) What is the effective date of spouse's/domestic partner's medical coverage?
Month_____ Day_____ Year_____
(Note: This request will not be processed unless or until this information is provided)

I certify that the above information is true. I understand that misrepresentation concerning any of the above data is a violation of Company Policy that may result in disciplinary action up to and including termination. I understand that I will need to immediately update the information on this form if the above circumstances change. I understand that if benefits are paid in error due to incorrect information or my failure to notify The Kroger Co. of changes, full recovery of paid claims will occur.

Associate's Signature: _____ Date: _____

Complete, sign, and forward this form to the Kroger Benefits Service Center at:
Telephone: 1-877-373-3397
Fax: 1-503-797-3799
E-Mail: KrogerBenefits@Kroger.com
Mailing Address: P.O. Box 42121
Portland, OR 97242-0121
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FOR OFFICE USE ONLY:

Form Received Date: _____ **CANCEL FEE _____ ADD FEE** _____

Effective Date: _____ Processed By: _____

Database Update Date: _____