



**QUALIFYING LIFE EVENT
FAX COVER SHEET**

**HUDSON'S BAY COMPANY
HBC EMPLOYER ID: 06125**

Please complete the information below and fax with your QLE documentation to **1-844-397-7261**.

Associate Name: _____

Associate ID number: _____

What is your Qualifying Event? Birth, Adoption, Marriage, Divorce, You or Your spouse employment status change, Gain or Loss of Coverage

Date of Event: _____

What documentation have you attached? Birth Certificate, Adoption Decree, Marriage License, Divorce Decree, Notice of Coverage for Gain or Loss of coverage event

I. Declaration

III. Acknowledgements

We understand and agree to the following terms:

1. We understand that all Associates who are covered by or applying for benefit plan coverage are subject to the same enrollment window period. There is a 31 day limit on the enrollment period, beginning on the date of the qualifying life event.
2. We agree to provide documentation promptly to verify our status, if requested. We understand that failure to provide such documentation within 31 days of the date of the request will result in the spouse's or partner's enrollment being denied or terminated, as the case may be.
3. We understand that Associate contributions for the civil union or domestic partner's health care coverage must be paid only on an after-tax basis and that any employer contributions for the domestic partner's health care coverage may be reported as taxable income to the Associate depending on applicable state law.
4. We have provided the information in this statement for use by HBC for the sole purpose of determining our eligibility for benefits and the appropriate federal, FICA and/or state tax treatment related to coverage under HBC's Benefits Program.

IV. Change in Status

We agree to notify HBC Benefits Service Center if there is any change in our status. If a change occurs which makes the non-HBC-Associate partner no longer eligible for benefits, we will notify the HBC Benefits Service Center within 31 days of such change. We will do so by providing the appropriate legal document verifying the termination of our relationship, or by filing a Statement of Termination of Civil Union/Domestic Partnership with a Discontinuation of Benefits form. The Statement of Termination shall affirm that the domestic partnership status is terminated as of its date of execution and that a copy of the Statement of Termination has been mailed to the other party by the partner authorizing such action.

V. Certification

We certify that the statements we made in this Certification are true and complete to the best of our knowledge and belief and that we meet all of the eligibility requirements of the benefit plans of HBC. We understand that the willful falsification of information contained in this Certification may result in termination of coverage, disciplinary action up to and including termination of employment at HBC, and, in addition, may result in civil action being brought against either or both of us for recovery of any losses, including all payments of the benefit plans of HBC, for any persons enrolled as eligible dependents including, without being limited to, reasonable attorney fees and court costs.

Sign below and return the completed form to your Corporate Benefits department.

Associate signature

Spouse/Partner signature

Associate's CHRIS/Oracle ID Social Security Number

Associate and Spouse/Partner Address

Approved for HBC Benefits

Name: _____

Date: _____