

Four Seasons Family of Companies
Spousal Coverage Verification Form
Effective January 1, 2027—December 31, 2027

The Four Seasons Produce, Inc. benefit plan provides primary medical insurance coverage for lawful spouses of Four Seasons Family of Companies' associates provided that the spouse is not employed or the spouse is not offered coverage through his or her employer. **This form must be completed if you are enrolling your spouse in medical coverage and must be returned prior to your benefit eligibility date.** Your spouse must have Section 2 completed by an authorized representative from their employer if they are currently employed.

Associate Name: _____

Please indicate the reason your spouse is eligible for medical coverage:

- ☐ Spouse is currently employed by the Four Seasons Family of Companies.
☐ Spouse is not employed.
☐ Spouse is self-employed and does not offer health insurance to any employees.
☐ Spouse is currently employed but not eligible for medical coverage. **(Complete Section 1 and Section 2 below)**

I understand that I must notify Human Resources as soon as possible but not longer than within 30 days if my spouse gains access to health insurance coverage elsewhere at any time during 2027. I understand that they become an ineligible dependent under the Four Seasons Produce, Inc. Benefit Plan as of the date that they are eligible for other coverage. Ineligible dependents will be removed from the plan, no contributions will be refunded, and claims incurred after the date of ineligibility will be denied.

Associate Signature

Date

Section 1—Complete if your spouse is currently employed. This section is to be completed by the Associate (please print legibly).

Spouse Name: _____

Spouse's Employer: _____

Phone Number of Spouse's Employer: _____

I confirm and certify that the information provided is true, accurate and complete. I understand that falsification of information is a violation of company policy, which is subject to corrective action up to and including termination of employment.

Failure to return the Spousal Coverage Verification Form will deem your spouse an ineligible dependent. Ineligible dependents will not be enrolled or will be removed from the plan, no contributions will be refunded, and claims incurred after the date of ineligibility will be denied.

Associate Signature

Date

Section 2—This section is to be completed by an authorized representative from the above named Spouse's Employer. Completed forms can be faxed to 717.721.2525 or emailed to benefits@fsproduce.com

1. Is medical coverage available to the spouse named above? ☐ Yes (skip to question 3) ☐ No

2. If No, based on their current status, will they become eligible in 2027? ☐ Yes, date eligible _____ ☐ No

3. Date medical coverage was first available to the spouse named above? _____

Authorized Representative Signature

Date

Name and Title of Authorized Representative (please print)

Phone number