VERIFICATION OF ELIGIBILITY FOR MEDICAL WORKING SPOUSE CONTRIBUTIONS

If your Spouse/Legally Recognized Partner (LRP) has medical coverage available through an employer or former employer and chooses not to enroll in that employer's medical plan, you may be required to pay a $40 per month working spouse contribution. Based on your answers below, and your applicable bargaining agreement, it will be determined if you should be paying working spouse contributions. **You must return this form by the required due date. If you do not return this form by the required due date, your spouse will be considered an ineligible dependent and coverage for your spouse will be terminated.**

Please read and answer "**Yes"** or "**No"** (check the applicable box) for the questions below. **The company reserves the right to validate all information provided on this form.**

1. Are you married—including common-law spouse—or do you have a Legally Recognized Partner (LRP)?	Yes ☐	No ☐
If your answer to question 1 is "No," please stop, and sign, date and return this document with your other required audit documents.		
2. Is your Spouse/Legally Recognized Partner (LRP) eligible to receive medical coverage from a current or former employer?	Yes ☐	No ☐
If your answer to question 2 is "Yes," please continue to the next question. Otherwise, please stop, and sign, date and return this document with your other required audit documents.		
3. Did your Spouse/Legally Recognized Partner (LRP) decline medical coverage through a current or former employer that was available this year?	Yes ☐	No ☐
If your answer to question 3 is "Yes," please continue to the next question. Otherwise, please stop, and sign, date and return this document with your other required audit documents.		
4. Did your Spouse/Legally Recognized Partner (LRP) receive more than $25,000 in income from all sources, including, but not limited to, employment, retirement, Social Security or disability plans in the previous year?	Yes ☐	No ☐
If your answer to question 4 is "Yes," please continue to the next question. Otherwise, please stop, and sign, date and return this document with your other required audit documents.		
5. Would your Spouse's/Legally Recognized Partner's (LRP) contribution through a current or former employer's plan have been less than $75 per month for individual coverage?	Yes ☐	No ☐
If your answer to question 5 is "Yes," please continue to the next question. Otherwise, please stop, and sign, date and return this document with your other required audit documents.		
6. Is your Spouse/LRP eligible for AT&T coverage as a current or former AT&T employee (including a retiree)?	Yes ☐	No ☐
If your answer to question 6 is "Yes," please continue to the next question. Otherwise, please stop, and sign, date and return this document with your other required audit documents.		
7. Is the contribution for your non-HMO AT&T medical plan equal to zero?	Yes ☐	No ☐
If your answer to question 7 is "Yes," please continue to the next question. Otherwise, please stop, and sign, date and return this document with your other required audit documents.		
8. Is the contribution for your Spouse's/LRP's non-HMO AT&T medical plan equal to zero?	Yes ☐	No ☐
Please sign below. You <u>must</u> return this document with your other required audit documents.		

EMPLOYEE/RETIREE CERTIFICATION: I certify that the information supplied above is true. I understand that I will need to immediately contact the AT&T Benefits Center if any of the above circumstances change. I also understand that intentional misrepresentation concerning any of the above information constitutes fraud and is a serious violation of Company Policy. Such a violation may result in legal action, financial consequences and/or disciplinary action up to, and including, dismissal.

Print Name of Employee/Retiree _____ Date _____

Signature of Employee/Retiree _____

Employee's/Retiree's Last 4 digits of Social Security number _____

This document summarizing the dependent eligibility provisions for AT&T health and welfare plan coverages is presented as a quick reference for general information only. For detailed terms and conditions of the AT&T health and welfare plans, consult the summary plan descriptions, summary of material modifications or the official plan documents. In all cases, the official plan documents shall govern and are the final authority on the terms of the plans. The AT&T companies reserve the right to amend, modify, suspend, or terminate any and all of their benefit plans, subject to any applicable collective bargaining agreement. Participation is neither a contract nor a guarantee of future employment.

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