



Your Fertility and Family Building Benefit

Rivian
2025 Plan Year



Progyny Global

Your employer has partnered with Progyny Global to offer you an easy-to-use reimbursement solution covering eligible fertility medical, fertility pharmacy, surrogacy, and adoption expenses, with advocacy support in your local language. You will be reimbursed for eligible fertility expenses up to the lifetime limit set by your employer in your country of residence. You can find a list of potential eligible fertility services detailed in *Appendix A*.

Progyny Global Onboarding

Before you begin treatment or receive any services from a fertility provider, please contact Progyny Global to ensure that you have all the necessary documents for reimbursement.

To start your onboarding, please contact Progyny Global by using the email address or toll-free number for your country of residence below.

You can also begin onboarding by submitting your registration information through the respective Progyny Global portal via this link:

<https://us-fnol.claims.global/progyny-rivian-AC-149732>

This site will direct you to create an account prior to registering. If you have any questions about setting up your account, please contact your Progyny Global Advocate.

| Country | Lifetime Maximum Amount Treatment, Medication, Adoption, and Surrogacy | Currency of Lifetime Maximum | Progyny Global Phone Number | Progyny Global Email Address |
|----------------|---|------------------------------|-----------------------------|--|
| Germany | 14,000.00 | EUR | 08002706027 | prognynglobal.Rivian@crowco.co.uk |
| Netherlands | 14,000.00 | EUR | 08000200579 | prognynglobal.Rivian@crowco.co.uk |
| Serbia | 1,646,900.00 | RSD | 381116963880 | prognynglobal.Rivian@crowco.co.uk |
| United Kingdom | 12,000.00 | GBP | 08000582730 | prognynglobal.Rivian@crowco.co.uk |

†Your benefit balance may be reduced based on utilization of your prior fertility benefit. Contact your Global Advocate to understand your balance.



When you register with Progyny Global, your Global Advocate will ask for the following information for both you and your covered dependent:

- Name of your employer
- Full name
- Date of birth
- Residential address
- Photo ID
- Contact information (email and telephone)
- Data privacy consent form(s). Please note a signed data privacy consent form is required to complete your registration.

Once the registration process is complete, you will receive your Progyny Global reference number. This reference number is your unique ID. When speaking with a Progyny Global Advocate, please have this reference number on hand. When communicating by e-mail, please include your name and your Progyny Global reference number in the subject line.



Understanding My Coverage

Selecting a Fertility Clinic/Agency

You can receive treatment or services from the provider or vendor of your choice. You are responsible for making this selection and Progyny Global cannot offer any advice or guidance with this decision.

Covered Dependents*

Your lifetime maximum benefit covers both you and your covered dependent. Services incurred by you and your partner are applied to the same lifetime maximum. Dependent children are not covered. *Your benefit balance may be reduced based on utilization of your prior fertility benefit. Contact your Global Advocate to understand your balance.

Eligible Expenses

Your employer has specified the expenses that may be covered by the Progyny Global benefit. Your fertility benefit covers eligible fertility medical, fertility pharmacy, surrogacy, and adoption expenses. A comprehensive list of these services is provided in *Appendix A*. Please note, expenses are only eligible for reimbursement if they are on your employer's list of covered services and are permitted by applicable law.

Submitting Eligible Expenses for Reimbursement

To be reimbursed for eligible expenses, you must submit a reimbursement request form and the required documentation to the Progyny Global country-specific email address. You must include your full name and Progyny Global reference number in the subject field of the email. Please contact your Global Advocate if you have any questions.

Reimbursement requests for eligible services must be received by Progyny Global within 90 days of the date on the invoice submitted. In the event your employment is terminated, you have 90 days to submit eligible expenses incurred prior to your termination date.

Fertility Medical and Fertility Pharmacy Expenses

To expedite processing time, please only submit your reimbursement request once you have completed treatment. After you've received treatment, you will need to submit the following documents:

- Reimbursement request form (*Appendix B*)
- Provider attestation form (*Appendix B*)
- Itemized invoice(s) for all services for which you are requesting reimbursement.
- Proof of payment for all services for which you are requesting reimbursement.

All documents should be sent in PDF form to the country-specific email address. **Please include your full name and Progyny Global reference number in the subject field of the email to ensure it is processed in a timely manner.**



Please note that reimbursement requests will not be approved: if the form is incomplete or inaccurate, if it is submitted more than 90 days after the invoice date, if you have already met your lifetime maximum, or if it does not contain eligible expenses that are permitted by applicable law. It is important to include all required documentation to ensure it is processed correctly. Partial reimbursements will be approved if the expense amount submitted exceeds your remaining lifetime maximum benefit or if only some of the expenses are eligible. Please contact your Global Advocate if you have any questions.

Surrogacy and Adoption Expenses

To receive reimbursement for eligible surrogacy or adoption expenses, you will need to submit the following documents:

- Reimbursement request form (*Appendix B*)
- A copy of a letter from your legal counsel verifying you are engaged in a legally binding arrangement or a signed copy of your agency agreement.
- Itemized invoice(s) for all services for which you are requesting reimbursement.
- Proof of payment for all services for which you are requesting reimbursement.

All submission documents should be sent as a PDF to the country-specific email address. **Please include your full name and Progyny Global reference number in the subject field of the email to ensure it is processed in a timely manner.**

Please note that reimbursement requests will not be approved: if the form is incomplete or inaccurate, if it is submitted more than 90 days after the invoice date, if you have already met your lifetime maximum, or if it does not contain eligible expenses that are permitted by applicable law. It is important to include all required documentation to ensure it is processed correctly. Partial reimbursements will be approved if the expense amount submitted exceeds your remaining lifetime maximum benefit or if only some of the expenses submitted are eligible. Please contact your Global Advocate if you have any questions.

Expense Validation and Reimbursement

Progyny Global will review and approve or deny all reimbursement requests in a timely fashion. Upon receipt of your submission, you will receive an email to collect your bank information for payment via electronic fund transfer. The email contains a unique hyperlink to a secure portal so you can safely enter the information. It is important that you provide this information when requested to facilitate timely processing. Once your submission is approved and your reimbursement routing details are received, you can expect to receive payment via electronic fund transfer to the account specified. If a submission is denied, Progyny Global will send a letter explaining the reason for the denial.

Reimbursement Currency

You can receive services in the country of your choice. Progyny Global will reimburse you in the same currency that you paid for your services. If that currency differs from the currency of your lifetime maximum benefit, Progyny Global will deduct the expense from your lifetime maximum benefit using the exchange rate at the time of reimbursement plus the cost for the exchange of the currency.



Eligible Fertility Treatment Expenses

Initial Diagnostics and Workup

| Service | Description |
|------------------------------|--|
| Initial diagnostics services | May include the following in-house tests (not all tests listed are required to be performed if not clinically necessary): initial consult, office visits, initial ultrasounds, TSH, Prolactin, AMH, day 2/3 labs (E2, FSH, LH, P4), semen analysis (for partner), venipunctures. |

Full Cycles

| Service | Description |
|---|--|
| IVF Fresh | Traditional Fresh, with fresh embryo transfer and if necessary cryopreservation of any balance of embryos. |
| IVF Freeze All | Freeze All Cycle / Embryo Banking and cryopreservation of any balance of embryos. |
| Frozen Embryo Transfer (FET) | Traditional frozen embryo transfer (FET). |
| Intrauterine Insemination (IUI) | IUI Stimulated or Unstimulated. |
| Egg Freezing | Fertility Preservation. |
| Frozen Oocyte Thaw with Fertilization and Embryo Transfer | Frozen Oocyte Thaw with fertilization and transfer and cryopreservation of any balance of embryos. |

Partial Cycles

| Service | Description |
|--|---|
| Frozen Oocyte Thaw with Fertilization and Cryopreservation | Frozen Oocyte Thaw with fertilization, cryopreservation of embryos, and no transfer. |
| Cycle Monitoring / Cancelled ART Cycle | Cycle Monitoring or cancelled ART Cycle (Traditional IVF, Freeze All Cycle, Egg Freezing) stimulation and monitoring. |
| IVF Cancelled after Aspiration | Traditional Fresh or Freeze All cancelled after Aspiration (immature/no viable oocytes) |
| IVF Cancelled Prior to Transfer | Traditional Fresh or Freeze All with fertilization cancelled prior to transfer (no viable embryos). |



| Service | Description |
|---------------------------------|---|
| IUI Cancelled | IUI Stimulated or Unstimulated cancelled prior to insemination. |
| FET Cancelled Prior to Transfer | Traditional FET cancelled prior to embryo transfer due to no viable embryos after thaw, may include monitoring. |

Donor Tissue (For Intended Parents)

| Service | Description |
|---|---|
| IVF Fresh with Donor Egg | Donor Egg with Fertilization (Fresh): includes monitoring of covered member (recipient), fertilization, transfer, and if necessary, cryopreservation of any balance of embryos. |
| IVF Freeze All with Donor Egg | Donor Egg with Fertilization (Freeze All): includes monitoring of covered member (recipient), fertilization, and cryopreservation of embryos. |
| IVF Fresh with Donor Egg and Donor Sperm | Donor Egg and Donor Sperm with Fertilization (Fresh): includes monitoring of covered member (recipient), fertilization, transfer, cryopreservation of any balance of embryos. |
| IVF Freeze All with Donor Egg and Donor Sperm | Donor Egg and Donor Sperm with Fertilization (Freeze All): includes monitoring of covered member (recipient), fertilization, and cryopreservation of embryos. |
| IVF Fresh with Donor Sperm | Donor Sperm Only: Traditional Fresh with fresh embryo transfer, cryopreservation of any balance of embryos. |
| IVF Freeze all with Donor Sperm | Donor Sperm Only: Freeze All Cycle / Embryo banking with cryopreservation of any balance of embryos. |

Surrogacy Embryology Services (For Intended Parents)

| Service | Description |
|--|---|
| Intended Parent Egg and Intended Parent Sperm with Surrogate | Intended Parent Egg and Intended Parent Sperm with Surrogate includes stimulation of intended parent for retrieval, fertilization, and cryopreservation but no embryo transfer. |
| Donor Egg and Intended Parent Sperm with Surrogate | Donor Egg and Intended Parent Sperm with Surrogate: fertilization and cryopreservation of embryos. |
| Donor Egg and Donor Sperm with Surrogate | Donor Egg and Donor Sperm: fertilization, cryopreservation of embryos. |



Stand Alone Services

| Service | Description |
|---------------------------------|--|
| ICSI | ICSI: Unlimited number of oocytes when not included in cycle's bundle. |
| Embryo Biopsy | Embryo Biopsy for PGT: unlimited number of embryos when not included in cycle's bundle. |
| PGT-A | Preimplantation Genetic Testing |
| HSG | Hysterosalpingography |
| SIS or SHG | Saline infusion sonohysterography |
| Office HSC | In-office hysteroscopy |
| Mock Transfer | Mock Transfer when needed but not part of another authorized service. |
| Embryo Thaw with PGT | Embryo Thaw in conjunction with previously frozen embryos which need to be biopsied for PGT. Authorized only for patients with a benefit when thaw is required to biopsy previously frozen embryos. |
| Assisted Hatching | Assisted Hatching: authorized only for patients with embryos previously cryopreserved earlier than Day 4 that require AH and extended culture. This code is to be used only when these services are not part of a Smart Cycle. |
| Extended Culture of Embryos | Extended Culture of Embryos (Authorized only for patients with embryos previously cryopreserved earlier than Day 4 and require extended culture: only when these services are not part of a Smart Cycle). |
| Mock Cycle | Mock Cycle (may include endometrial biopsy): for approved indications only. Authorized only for patients with failed implantation, for a cycle including donor oocytes, or other approved indications. |
| Elective Semen Cryopreservation | Elective Semen Cryopreservation (including Semen Analysis): only payable if service is separately authorized and performed. |
| Tissue transportation | Tissue Transportation: tissue transportation for the shipment of tissue between clinics and/or storage facilities. |
| Embryo storage | Embryo storage. |
| Oocyte storage | Oocyte storage. |

The list above includes fertility treatment expenses that may be eligible for reimbursement. Progyny Global will only reimburse such expenses if both you and your provider attest that the services are permitted by applicable law. Please reach out to your Global Advocate with any questions about this list or the reimbursement process.



Eligible Fertility Medication Expenses

Compounds of medications in any of the categories below, used in combination with fertility treatment, are eligible for reimbursement.

| Category | Description | Common Trade Names |
|---------------------------|--|---|
| GnRH Agonist / Antagonist | Used in IVF to induce folliculogenesis via prevention of endogenous LH surge and timed oocyte retrieval. | Leuprolide Lupron Depot Orgalutran Cetrotide Eligard Viadur Lupron Synarel Zoladex Antagon Ganirelex Acetate Factrel Lutrepulse |
| Dopamine agonist | Used to correct a hormonal imbalance that can prevent ovulation. | Dostinex Parlodel Cycloset Cabergoline Bromocriptine |
| Stimulant | Used to induce ovulation by blocking estrogen receptors to stimulate the production of more FSH (also known as anti-estrogen). | Clomiphene citrate Clomid Serophene Letrozole tablets Femara |
| Estrogen | Used during IVF to thicken the endometrial (uterine) lining. | Estradiol Valerate Estradiol tablets Estradiol patch Estradot patch Prometrium Cimara Climarelle Vivelle Menorest Femiest Delestrogen Menostar |



| Category | Description | Common Trade Names |
|--------------|--|--|
| hMG | Used to simulate egg development and increased the number of eggs developed in a single cycle. | Menopur Menotropin Metrodin Pergonal Repronex |
| FSH | Used to stimulate the ovaries to produce follicles. | Gonal F Follitropin alpha Bravelle Urofollitropin Fertinex Follistim Follitropin beta Organon Puregon Rekovellet Follitropin delta |
| hCG | Used to stimulate the final development and release of mature eggs at the time of ovulation. | Ovidrel Choriogonadotropin alfa Pregnyl Novarel Profasi |
| Progesterone | Used to maintain the endometrial lining during treatment and early pregnancy. | Progesterone in oil Lutinus (progesterone vaginal) Endometrin insert (progesterone vaginal) Prochieve (progesterone gel) Crinone (progesterone gel) |

The list above includes fertility medication expenses that may be eligible for reimbursement. Progyny Global will only reimburse such expenses if both you and your provider attest that the services are permitted by applicable law. Please reach out to your Global Advocate with any questions about this list or the reimbursement process.



Eligible Adoption Expenses

| Eligible Expenses | Ineligible Expenses |
|---|--|
| <ul style="list-style-type: none"> - Application fees - Home studies - Consultant/specialist fees - Agency and placement fees - Legal fees and court costs - Immigration, immunization, and translation fees - Transportation, meals, lodging for the adoptive parents, and/or adopted child(ren) only - Parent, child, and family adoption counselling - Costs incurred by registered domestic partner or same-sex spouse to adopt his or her partner's child(ren) - Visa and passport fees for adopted child(ren) - Medical assessment of adopted child(ren) - Temporary foster care expenses - Fees associated with the adoption of the child(ren) through a legally recognized surrogate arrangement | <ul style="list-style-type: none"> - Adoptions that aren't legally recognized - Voluntary donations or contributions - Expenses for adopting an individual aged 18 or older, unless they are physically or mentally incapable of self-care - Costs for personal items, food, and clothing for the parents or child(ren) - Expenses already paid for or reimbursed by another employer, benefit, program, or party - Costs paid using funds received from any other program - Any expenses that violate any applicable law |

The list above includes adoption expenses that may be eligible for reimbursement. Progyny Global will only reimburse such expenses if you attest that the services are permitted by applicable law. Please reach out to your Global Advocate with any questions about this list or the reimbursement process.



Eligible Surrogacy Expenses

| Eligible Expenses | Ineligible Expenses |
|--|--|
| <ul style="list-style-type: none"> - Surrogacy agency or legal fees - IVF and medical costs related to surrogacy - Medical expenses related to a surrogate's pregnancy (which may include but are not limited to surrogate's maternity insurance, surrogate's deductible, surrogate's co-insurance) - Medical expenses for the intended parent that are not covered under the current medical policy - Travel expenses for the intended parents or surrogate related to the surrogacy - Consultant/specialist fees - Donor agency, psych, and/or legal fees - Fees associated with the purchase of fresh or already frozen donor tissue - Travel expenses for the intended parents or surrogate related to donor services - Embryo donation fees including but not limited to admin, legal, and psych fees - Consultant/specialist fees | <ul style="list-style-type: none"> - Expenses already paid for or reimbursed by another employer, benefit, program, or party - Costs paid using funds received from any other program - Expenses already paid for or reimbursed by another employer, benefit, program, or party - Surrogacy or donation arrangements that are not legally recognized - Any expenses that violate any applicable law - Medical expenses related to an intended parent's pregnancy |

The list above includes surrogacy expenses that may be eligible for reimbursement. Progyny Global will only reimburse such expenses if you attest that the services are permitted by applicable law. Please reach out to your Global Advocate with any questions about this list or the reimbursement process.



INSTRUCTIONS FOR FERTILITY TREATMENT AND MEDICATION REIMBURSEMENT REQUESTS

Please fill out this form to submit eligible fertility treatment and medication expenses for reimbursement to Progyny Global.

Please review the instructions below to ensure that you complete the reimbursement form correctly. Refer to your Benefit Overview document for more information about eligibility criteria, eligible, and ineligible expenses or reach out to your Global Advocate.

1. Please complete all required fields and attach all applicable itemized invoices and proofs of payment. Once complete, email this form and all documents to your country specific email address.
2. You must use a separate form for each new request until you exhaust the lifetime maximum benefit amount offered by your employer. If you are the dependent on the plan, please include the subscriber details.
3. Please fill out the form electronically or print clearly in black or blue ink. The signature must be by hand in black or blue ink.
4. Enter the expense amount in number format (example: 12345.00). Provide the total amount of the expenses submitted at the end of the expense submitted section.
5. Include a copy of the Provider Attestation Form completed by each clinic and pharmacy where you received services or medication with your submission.
6. In addition to the completed Provider Attestation Form(s), Progyny Global requires copies of all applicable itemized invoices and proofs of payment to process the reimbursement request. Progyny Global cannot accept balance due statements and cancelled checks in place of supporting documentation. Receipts cannot show “credit card payment.”
7. Please scan and send the completed Reimbursement Request form, Provider Attestation Form(s), and copies of all applicable itemized invoices and proofs of payment to the designated Progyny Global email address.
8. Itemized invoices must include:
 - a. The date of service
 - b. The name of the provider and clinic/pharmacy
 - c. The name of member
 - d. The type of service/medication
 - e. Charge for the service (in currency paid)
9. Proof of payment must include (in currency paid):
 - a. For check payment, a copy of cashed check showing:
 - i. The name of the provider/vendor
 - ii. Front and back of the cashed check
 - b. For debit/credit card payment: Receipt/Email/Statement with transaction information, including name of the provider/vendor and amount paid



- c. For cash payment: Receipt from provider/vendor showing the name of the provider/vendor and amount paid



FERTILITY TREATMENT AND MEDICATION REIMBURSEMENT REQUEST

MEMBER INFORMATION

IF YOU ARE THE PARTNER FILLING OUT THIS REQUEST, PLEASE INCLUDE THE SUBSCRIBER DETAILS

| | |
|---|---------------------------|
| EMPLOYER NAME: | |
| EMPLOYEE NAME (first and last): | DATE OF BIRTH (MM/DD/YY): |
| PARTNER'S NAME, IF APPLICABLE (first and last): | DATE OF BIRTH (MM/DD/YY): |
| EXPENSE SUBMISSION TYPE(S): <input type="checkbox"/> TREATMENT <input type="checkbox"/> MEDICATION | EMPLOYEE ID: |

EXPENSES SUBMITTED FOR REIMBURSEMENT

| Date of Service (MM/DD/YYYY) | Clinic/Pharmacy Name and Address | Provider or Pharmacist Name | Description of Service | Expense Amount | Currency |
|---------------------------------|-------------------------------------|--------------------------------|------------------------|-------------------|----------|
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ATTACHMENTS

- A copy of the signed Provider Attestation Form.
- The itemized invoice(s) for all services for which you are requesting reimbursement.
- Proof of payment for all services for which you are requesting reimbursement.

By submitting this form, I hereby certify the following information as true, complete and correct:

- I certify that I am eligible to participate in the Reimbursement Program and if applicable, my partner is eligible to participate in the Reimbursement Program.
- I certify that I am claiming reimbursement only for services that are permitted by applicable law and are also eligible expenses as identified by my employer, and I have only provided invoices and receipts for such services.
- I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under any other employer, benefit, program or party, whether governmental or private.

Employee's Signature

Date



PROGYNY GLOBAL – PROVIDER ATTESTATION FORM

Submission of this claim constitutes certification that the billing information indicated on the invoice is true, accurate, and complete.

Clinic/Pharmacy Name: _____

Provider Name: _____

Provider Address: _____

Patient Name: _____

Date(s) of Service: _____

By submitting this form, I hereby attest that the following information is true, accurate and complete to the best of my knowledge:

- I certify that I verified the identity of the individual(s) named on the invoice.
- I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under any other program or party, whether governmental or private.
- I certify that I, the Provider, have a valid license or certification to practice medicine and the services performed are within the scope of such license or certification.
- I certify that the clinic or pharmacy where services were delivered is registered with and/or licensed by the country's department or ministry of health or other relevant national and local government body.
- I certify that all services delivered are permitted by applicable law.
- I certify that the services shown on this form were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision.

Provider's Signature

Date



INSTRUCTIONS FOR SURROGACY AND ADOPTION REIMBURSEMENT REQUEST

Please fill out this form to submit eligible surrogacy or adoption expenses for reimbursement to Progyny Global.

Review the instructions below to ensure that you complete the reimbursement form correctly. Please refer to your Benefit Overview document for more information about eligibility criteria, eligible, and ineligible expenses or reach out to your Global Advocate.

1. Please complete all required fields and attach all applicable itemized invoices, proofs of payment, and legal or agency agreement. Once complete, email this form and all documents to your designated country email address.
2. You must use a separate form for each new request until you exhaust the lifetime maximum benefit amount offered by your employer. If you are the dependent on the plan, please include the subscriber details.
3. Please fill out the form electronically or print clearly in black or blue ink. The signature must be by hand in black or blue ink.
4. Enter the expense amount in number format (example: 12345.00). Provide the total amount of the expenses submitted at the end of the expense submitted section.
5. Include a copy of a letter from your Legal Counsel verifying you are engaged in a legally binding arrangement or provide a signed copy of your Agency Agreement with your submission.
6. In addition to the legal or agency agreement, Progyny Global requires the itemized invoice and proof of payment to process the reimbursement request. Progyny Global cannot accept balance due statements and cancelled checks in place of supporting documentation. Receipts cannot show “credit card payment.”
7. Please scan and send the completed Reimbursement Request form, legal or agency agreement, and copies of all applicable itemized invoices and proofs of payment to the designated Progyny Global email address.
8. Itemized invoices must include:
 - a. The date of service
 - b. The name of the provider/vendor
 - c. Member name
 - d. The type of service/procedure code
 - e. Charge for the service (in currency paid)
9. Proof of payment must include (in currency paid):
 - a. For check payment, a copy of cashed check showing:
 - i. Provider/vendor
 - ii. Front and back of the cashed check
 - b. For debit/credit card payment: Receipt/Email/Statement with transaction information
 - c. For cash payment: Receipt from provider/vendor



SURROGACY AND ADOPTION REIMBURSEMENT REQUEST

MEMBER INFORMATION

IF YOU ARE THE PARTNER FILLING OUT THIS REQUEST, PLEASE INCLUDE THE EMPLOYEE DETAILS

| | |
|--|---------------------------|
| EMPLOYER NAME: | |
| EMPLOYEE'S NAME (first and last): | DATE OF BIRTH (MM/DD/YY): |
| PARTNER'S NAME (first and last): | DATE OF BIRTH (MM/DD/YY): |
| EXPENSE SUBMISSION TYPE: <input type="checkbox"/> ADOPTION <input type="checkbox"/> SURROGACY | EMPLOYEE ID: |

EXPENSES SUBMITTED FOR REIMBURSEMENT

| Date of Service (DD/MM/YYYY) | Vendor Name and Address | Description of Service | Expense Amount | Currency |
|---------------------------------|----------------------------|------------------------|-------------------|----------|
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| | | | TOTAL | |

ATTACHMENTS

- A copy of a letter from your Legal Counsel verifying you are engaged in a legally binding arrangement or provide a signed copy of your Agency Agreement.
- The itemized invoice(s) for all services for which you are requesting reimbursement.
- Proof of payment for all services for which you are requesting reimbursement.

By submitting this form, I hereby certify the following information as true, complete and correct:

- I certify that I am eligible to participate in the Reimbursement Program and if applicable, my partner is eligible to participate in the Reimbursement Program.
- I certify that I am claiming reimbursement only for services that are permitted by applicable law and are also eligible expenses as identified by my employer, and I have only provided invoices and receipts for such services.
- I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under any other employer, benefit, program or party, whether governmental or private.

Employee’s Signature

Date