

**Arthur J. Gallagher & Co.**  
**VEBA MEDICAL OPTIONS ENROLLMENT FORM**

**2024**

New Hire       Annual Enrollment       Life Event Change       Other \_\_\_\_\_

\_\_\_\_\_  
Last Name                      First Name                      M.I.                      Employee Location                      Work Phone

\_\_\_\_\_  
Home Street Address                      City                      State                      Zip  
Not Required                      Not Required

\_\_\_\_\_  
Social Security No.                      Employee #                      Date of Birth                      M/F                      Date of Hire                      Benefits Eff. Date

**VEBA Medical**

Plan Options (Select One):

KAISER HMO \$20       UHC HARMONY \$20/\$30       Waive Coverage

Coverage Level (Select One if Enrolling for Coverage):

Employee Only       Employee + Children       Employee + Spouse       Employee + Family  
 Employee + Domestic Partner\*       Employee + Domestic Partner\* + Children

**To complete enrollment, you must select dependents to include in coverage on the *Dependent Designation Form*.**

*Note: Coverage is effective on the first day of the month after enrollment. If enrolling during Annual Enrollment, coverage is effective on January 1.*

IRC Section 125 permits tax-favored pre-tax deductions to pay for medical coverage. If you want contributions to be deducted on an **after-tax** basis for your VEBA medical option, please circle:    Medical

**Certifications**

**Special Enrollment Periods with Life Events or Family Status Changes** - applicable to Medical, Dental and Vision: I understand that I may, in the future, **enroll or drop** coverage for myself and/or my dependents **provided I do so within 31 days** of the following events: marriage; divorce; birth; adoption or placement for adoption of a child; death or ineligibility of a dependent; the involuntary loss of other coverage (including COBRA continuation coverage); termination, commencement, or change in employment status of me or my spouse or registered domestic partner; a significant change in health coverage attributable to my spouse's or registered domestic partner's employment; a court order; or entitlement to Medicare and/or Medicaid. My election change must be consistent with my life event or family status change. **If I fail to make my request within 31 days, I will have to wait until the next Annual Enrollment Period.**

I authorize Arthur J. Gallagher & Co. to deduct the cost of the benefits I have elected from my pay. I understand that VEBA Medical Plan deductions are not prorated. Mid-year life events that initiate a change between a VEBA plan and a BCBS Medical Plan option may result in dual coverage, gaps in coverage or multiple payroll deductions. The coverage dates for a newborn child or adopted child varies between VEBA medical plan options.

\*I understand that my Domestic Partner must meet the qualifications for a Domestic Partner under the Gallagher Domestic Partner Policy, children must meet the definition of eligible dependent within each plan, and that enrolling a Domestic Partner in Medical or Dental coverage could have significant income tax implications.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Arthur J. Gallagher & Co.**  
**DENTAL PLANS/VISION PLAN ENROLLMENT FORM**

**2024**

New Hire       Annual Enrollment       Life Event Change       Other \_\_\_\_\_

\_\_\_\_\_  
Last Name      First Name      M.I.      Employee Location      Work Phone

\_\_\_\_\_  
Home Street Address      City      State      Zip  
Not Required      Not Required

\_\_\_\_\_  
Social Security No.      Employee #      Date of Birth      M/F      Date of Hire      Benefits Eff. Date

**Dental Plans**

Plan Options (Select One):

Standard Plan       Enhanced Plan       Waive Coverage (Complete Dependent Designations Form)

Coverage Level (Select one if Enrolling for Coverage):

Employee Only       Employee + Children       Employee + Spouse       Employee + Family  
 Employee + Domestic Partner\*       Employee + Domestic Partner\* + Children

**To complete enrollment, you must select dependents to include in coverage on the *Dependent Designation Form*.**

**Vision Plan**

Plan Options (Select One):

PPO Vision plan       Waive Coverage (Proceed to Group Legal Section Below)

Coverage Level (Select One if Enrolling for Coverage):

Employee Only       Employee + Children       Employee + Spouse       Employee + Family  
 Employee + Domestic Partner\*       Employee + Domestic Partner\* + Children

**To complete enrollment, you must select dependents to include in coverage on the *Dependent Designation Form*.**

IRC Section 125 permits tax-favored pre-tax deductions to pay for medical, dental and vision coverage. If you want contributions to be deducted on an **after-tax** basis for any of these enrollments, please **circle** each of them:      Dental      Vision

**Certifications**

**Special Enrollment Periods with Life Events or Family Status Changes** - applicable to Dental and Vision: I understand that I may, in the future, **enroll or drop** coverage for myself and/or my dependents **provided I do so within 31 days** of the following events: marriage; divorce; birth; adoption or placement for adoption of a child; death or ineligibility of a dependent; the involuntary loss of other coverage (including COBRA continuation coverage); termination, commencement, or change in employment status of me or my spouse or registered domestic partner; a significant change in health coverage attributable to my spouse's or registered domestic partner's employment; a court order; or entitlement to Medicare and/or Medicaid. My election change must be consistent with my life event or family status change. **If I fail to make my request within 31 days, I will have to wait until the next Annual Enrollment Period.**

\*I understand that my Domestic Partner must meet the qualifications for a Domestic Partner under the Gallagher Domestic Partner Policy, children must meet the definition of eligible dependent within each plan, and that enrolling a Domestic Partner in Medical or Dental coverage could have significant income tax implications.

I authorize Arthur J. Gallagher & Co. to deduct the cost of the benefits I have elected from my pay.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

**Arthur J. Gallagher & Co.**  
**ACCIDENT INSURANCE/CRITICAL ILLNESS/ HOSPITAL INDEMNITY INSURANCE/IDENTITY**  
**PROTECTION ENROLLMENT FORM**

2024

New Hire       Annual Enrollment       Life Event Change       Other \_\_\_\_\_

\_\_\_\_\_  
Last Name                      First Name                      M.I                      Employee Location                      Work Phone

\_\_\_\_\_  
Home Street Address                      City                      State                      Zip  
Not Required                      Not Required

\_\_\_\_\_  
Social Security No.                      Employee #                      Date of Birth                      M/F                      Date of Hire                      Benefits Eff. Date

**Accident Insurance**

Plan Options (Select One):  
 **Enroll**                       **Waive Coverage**

Coverage Level (Select One if Enrolling for Coverage):  
 Employee Only                       Employee + Children                       Employee + Spouse                       Employee + Family  
 Employee + Domestic Partner\*                       Employee + Domestic Partner\* + Children

**To complete enrollment, you must select dependents to include in coverage on the Dependent Designation Form.**

**Critical Illness Insurance**

Plan Options (Select One):  
 **Option 1 - (\$10,000)**                       **Option 2 - (\$20,000)**                       **Option 3 - (\$30,000)**                       **Waive Coverage**

Coverage Level (Select One if Enrolling for Coverage):  
 Employee Only                       Employee + Children                       Employee + Spouse                       Employee + Family  
 Employee + Domestic Partner\*                       Employee + Domestic Partner\* + Children

**To complete enrollment, you must select dependents to include in coverage on the Dependent Designation Form.**

**Hospital Indemnity Insurance**

Plan Options (Select One):  
 **Enroll**                       **Waive Coverage**

Coverage Level (Select One if Enrolling for Coverage):  
 Employee Only                       Employee + Children                       Employee + Spouse                       Employee + Family  
 Employee + Domestic Partner\*                       Employee + Domestic Partner\* + Children

**To complete enrollment, you must select dependents to include in coverage on the Dependent Designation Form.**

**Identity Protection Program**

Plan Options (Select One):  
 **Enroll**                       **Waive Coverage**

Coverage Level (Select One if Enrolling for Coverage):  
 Employee Only                       Employee + Children                       Employee + Spouse                       Employee + Family  
 Employee + Domestic Partner\*                       Employee + Domestic Partner\* + Children

**To complete enrollment, you must select dependents to include in coverage on the Dependent Designation Form.**

**Certifications**

**Special Enrollment Periods with Life Events or Family Status Changes** -I understand that if I enroll in Accident Insurance, Critical Illness, Hospital Indemnity Insurance or Identity Protection, my opportunity to change my coverage mid-year is very limited. I will only be able to make the mid-year changes in the following events: Divorce, Death or Dependent reaching limiting age. **If I fail to make my request within 31 days, I will have to wait until the next Annual Enrollment Period.** I may waive coverage in the above plans at any time.

\*I understand that my Domestic Partner must meet the qualifications for a Domestic Partner under the Gallagher Domestic Partner Policy, children must meet the definition of eligible dependent within each plan.

I authorize Arthur J. Gallagher & Co. to deduct the cost of the benefits I have elected from my pay. Premiums for Accident, Critical Illness, Hospital Indemnity and Identity Protection are paid through after-tax deductions

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Arthur J. Gallagher & Co.**  
**FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM**

**2024**

New Hire       Annual Enrollment       Life Event Change       Other \_\_\_\_\_

\_\_\_\_\_  
Last Name                      First Name                      M.I.                      Employee Location                      Work Phone

\_\_\_\_\_  
Home Street Address                      City                      State                      Zip  
Not Required                      Not Required

\_\_\_\_\_  
Social Security No.                      Employee #                      Date of Birth                      M/F                      Date of Hire                      Benefits Eff. Date

**Health Care Flexible Spending Account Plan**

Coverage Option (Select One):

Enroll

Enter **Annual** Amount You Wish to Contribute to Your FSA:      \$ \_\_\_\_\_      minimum contribution=\$100  
maximum contribution = \$3,200

Your annual contribution will be divided by the number of (remaining) pay periods in the plan year and deducted in equal bi-weekly amounts from each pay.

If you enroll in the **PPO+HSA 1** or **PPO+HSA 2** Medical/Rx plan, your Health Care Flexible Spending Account Plan will be a limited-use account in accordance with IRS regulations. Vision and dental expenses, and medical expenses that **exceed** your plan deductible will be eligible for reimbursement from your FSA. Out-of-pocket expenses that are applied to your plan deductible will **not** be eligible for reimbursement from your Health Care FSA.

If you enroll in the **PPO+HCA** Medical/Rx plan, all eligible medical expenses, including those applied to your plan deductible, can be reimbursed from your Health Care FSA.

Waive - I do not want to participate in the Health Care Flexible Spending Account Plan

**Dependent Day Care Flexible Spending Account Plan**

Enroll

Enter **Annual** Amount You Wish to Contribute to Your FSA:      \$ \_\_\_\_\_      minimum contribution=\$100  
maximum contribution = \$5,000

Your annual contribution will be divided by the number of (remaining) pay periods in the plan year and deducted in equal bi-weekly amounts from each pay.

Waive - I do not want to participate in the Dependent Day Care Flexible Spending Account Plan

**Certifications**

I understand the Flexible Spending Account Plan options available to me and the choices I have made.

I understand that balances over \$10 but not exceeding \$640 in the Health Care Flexible Spending Account Plan may be carried over into 2025. I further understand that I will lose any unused Dependent Day Care FSA balances of any amount and/or Health Care FSA balances of less than \$10 or more than \$640 that remain in my account(s) at the end of each Plan Year. (However, I have until April 15th of the following calendar year to submit claims incurred during the Plan Year for the Dependent Care FSA Account and Health Care Account.

I understand I may not change or stop my deposits to these accounts during the Plan Year **UNLESS** I have a life event or family status change, my election change is consistent with my life event change, **AND** I submit my change to Corporate Human Resources **WITHIN 31 DAYS** of the life event.

**Examples of life events or family status changes are:** marriage; divorce; birth; adoption or placement for adoption of a child; death or ineligibility of a dependent; the involuntary loss of other coverage (including COBRA continuation coverage); termination, commencement, or change in the employment status of me or my spouse; a significant change in health coverage attributable to my spouse's employment; a court order; or entitlement to Medicare or Medicaid.

My signature on this form certifies to the best of my knowledge the information on this form is accurate, and I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.

I authorize Arthur J. Gallagher & Co. to automatically direct deposit my Flexible Spending Plan reimbursements into my personal bank account on file with Health Equity, the Flexible Spending Account Plan Administrator. This includes my authorization to correct any entries made in error.

As a **NEW EMPLOYEE**, I understand that I have **15 DAYS** from my date of hire to enroll.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Arthur J. Gallagher & Co.**  
**LEGAL SERVICES/GPEL/ENROLLMENT FORM**

2024

New Hire       Annual Enrollment       Life Event Change       Other \_\_\_\_\_

\_\_\_\_\_  
Last Name                      First Name                      M.I.                      Employee Location                      Work Phone

\_\_\_\_\_  
Home Street Address                      City                      State                      Zip  
Not Required                      Not Required

\_\_\_\_\_  
Social Security No.                      Employee #                      Date of Birth                      M/F                      Date of Hire                      Benefits Eff. Date

**Legal Services Plan**

Plan Options (Select One):

**Enroll**                       **Waive Coverage**

Coverage Level

Enrollment in the Legal Services Plan automatically includes coverage for eligible dependents.

Premiums

Legal Services Plan premiums are paid through after-tax payroll deductions

**Group Personal Excess Liability Insurance Plan**

Coverage Level (Select One)

**Enroll and Purchase Coverage**

Please note: The plan requires you to carry certain levels of underlying coverage under your primary liability insurance

Enter Excess Liability Coverage Limit **(Required)**:

(Your enrollment cannot be processed without a Coverage Limit indicated here.)

(you may select excess liability limits ranging from \$2 Million, \$5 Million or \$10 Million)

Enter Un/Underinsured Motorist Coverage Limit **(Required)**:

(Your enrollment cannot be processed without a Coverage Limit indicated here.)

(you may select Un/Underinsured Motorist limits of \$1 Million or \$2 Million)

**Waive Coverage**

Enrollment in this plan is limited to once a year during Annual Enrollment.

**Company-Provided Life Insurance**

Gallagher provides all regular full-time employees with Life Insurance and AD&D benefits equal to 1.5 x annual earnings up to \$1 million. The company also provides a spouse/domestic partner benefit of \$5,000 and \$2,500 worth of coverage for each tax-dependent child. **You must designate beneficiaries for this benefit in the application process established by the insurance carrier.**

**Certifications**

**Special Enrollment Periods with Life Events or Family Status Changes** - applicable to Medical, Dental, FSA and Vision: I understand that I may, in the future, **enroll or drop** coverage for myself and/or my dependents **provided I do so within 31 days** of the following events: marriage; divorce; birth; adoption or placement for adoption of a child; death or ineligibility of a dependent; the involuntary loss of other coverage (including COBRA continuation coverage); termination, commencement, or change in employment status of me or my spouse or registered domestic partner; a significant change in health coverage attributable to my spouse's or registered domestic partner's employment; a court order; or entitlement to Medicare and/or Medicaid. My election change must be consistent with my life event or family status change. **If I fail to make my request within 31 days, I will have to wait until the next Annual Enrollment Period.** Changes to the Legal Services Plan and Group Personal Excess Liability Insurance Plan can only be made during Annual Enrollment.

\*I understand that my Domestic Partner must meet the qualifications for a Domestic Partner under the Gallagher Domestic Partner Policy, children must meet the definition of eligible dependent within each plan, and that enrolling a Domestic Partner in Medical or Dental coverage could have significant income tax implications.

I authorize Arthur J. Gallagher & Co. to deduct the cost of the benefits I have elected from my pay.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

**Arthur J. Gallagher & Co.**  
**DEPENDENT DESIGNATION FORM**

**2024**

New Hire       Annual Enrollment       Life Event Change       Other \_\_\_\_\_

Last Name	First Name	M.I.	Employee Location	Work Phone
Home Street Address <small>Not Required</small>	City <small>Not Required</small>		State	Zip
Social Security No.	Employee : Date of Birth		M/F	Date of Hire
				Benefits Eff. Date

**Dependent Designations**

List the family members you wish to cover under your benefits; enter the codes referenced below for each of the plan(s) under which each dependent should be covered.

Medical = **M** Dental = **D** Vision = **V** Accident Insurance = **ACC** Critical Illness = **CI** Hospital Indemnity = **HI** Identity Protection = **ID**

Spouses, domestic partners (as defined in the Arthur J. Gallagher & Co. Domestic Partner Policy) and children up to the age of 26 are eligible for dependent coverage in the medical, dental, vision, accident insurance, critical illness and hospital indemnity plans. There is no age limit for children under the identity protection plan as long as the child lives with you or is financially dependent on you. (Children include stepchildren, adopted children, and foster children). Spouses, domestic partners, and children who qualify as tax dependents (see following page) are eligible for Company-Provided Life and AD&D coverage through Gallagher.

**To avoid delays in beginning coverage, please provide all data requested for each dependent listed.**

	Name	Date of Birth	Gender (M/F)	Social Security No.	Tax-Dependent? (Y/N) <small>For guidance, see attached document</small>	List codes for each plan(s) under which dependent should be covered
Spouse or Domestic Partner*	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____

**While not required at this time, Gallagher reserves the right to request proof in the future that your dependents meet the eligibility criteria defined in the plan(s).**

**Certifications**

**Special Enrollment Periods with Life Events or Family Status Changes** - applicable to Medical, Dental and Vision: I understand that I may, in the future, **enroll or drop** coverage for myself and/or my dependents **provided I do so within 31 days** of the following events: marriage; divorce; birth; adoption or placement for adoption of a child; death or ineligibility of a dependent; the involuntary loss of other coverage (including COBRA continuation coverage); termination, commencement, or change in employment status of me or my spouse or registered domestic partner; a significant change in health coverage attributable to my spouse's or registered domestic partner's employment; a court order; or entitlement to Medicare and/or Medicaid. My election change must be consistent with my life event or family status change. Mid year changes to Accident, Critical Illness, Hospital Indemnity and Identity Protection will only be allowed in the case of Divorce, Death, Dependent reaching limiting age. **If I fail to make my request within 31 days, I will have to wait until the next Annual Enrollment Period.**

\*I understand that my Domestic Partner must meet the qualifications for a Domestic Partner under the Gallagher Domestic Partner Policy, children must meet the definition of eligible dependent within each plan, and that enrolling a Domestic Partner in Medical or Dental coverage could have significant income tax implications.

I authorize Arthur J. Gallagher & Co. to deduct the cost of the benefits I have elected from my pay.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



## ***Tax Dependent Status***

To properly set up your benefits, Gallagher requires you to indicate whether each of your family members (spouse, domestic partner, child, or other family member) is considered a tax dependent under IRC Section 152. Loosely defined, a tax dependent is an individual that you can ‘claim’ as a dependent when you file your federal income taxes. Legal spouses are considered tax dependents; the tax dependent status of other family members can be determined using two other categories defined by the IRS, **Qualifying Child** and **Qualifying Relative**.

**INSTRUCTIONS:** Compare the two definitions below to the circumstances of each of your family members. If all of the criteria within one of the definitions apply to a family member, then you should identify that individual as your tax dependent when you add him/her to myHR and/or complete your benefits enrollment.

Definition 1: A **Qualifying Child** Tax Dependent is an individual who meets all of the following criteria:

- bears a relationship\* to a taxpayer; and
- has the same principal place of abode as the taxpayer for more than one-half of the taxable year; and
- is under age 19 or between age 19 and 24 and a full-time student; and
- has not provided more than one-half of his/her own support during the year; and
- has not filed a joint tax return with his or her spouse for the year

\*Relationship includes son or daughter, stepson or stepdaughter, legal adopted son or daughter, and eligible foster child.

This definition should only be used to determine the tax dependent status of children within your family; spouses, domestic partners, and other family members cannot be considered tax dependents under the **Qualifying Child** definition.

Definition 2: A **Qualifying Relative** Tax Dependent is an individual who meets all of the following criteria:

- bears a relationship\* to a taxpayer; and
- is a member of the taxpayer’s household during the year; and
- has the same principal place of abode as the taxpayer for the year; and
- is a U.S. citizen, U.S. national, or a resident of the U.S., Canada, or Mexico; and
- obtained more than one-half of his/her support during the year from the taxpayer; and
- is not a spouse or qualifying child of the taxpayer.
- income limit for other than health benefits

\*Relationship includes a brother, sister, stepbrother or stepsister; father, mother or ancestor of either; stepfather or stepmother; son or daughter of a brother or sister of the taxpayer; brother or sister of the father or mother of the taxpayer; son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

This definition can be used to determine the tax dependent status of any individual, including domestic partners and children.

**\*\*The Impact of Tax Dependent Status on Benefit Eligibility & Enrollment\*\***

- 1) For Gallagher benefits, the eligibility of and cost of coverage for a spouse is unrelated to tax dependent status.
- 2) A child’s eligibility for Gallagher’s health plans (medical, dental, vision, supplemental health plans and flexible spending account) is based only on age. A child (as defined by the plans) can be covered until age 26 regardless of tax dependent status.
- 3) Eligibility for dependent child coverage under Gallagher’s life insurance, Identity Protection, Group Legal and AD&D plans, however, is determined by a child’s tax dependent status. To ensure that the proper benefit eligibility and enrollment options are available to you for dependent child coverage, you should identify your child as a tax dependent if he/she meets the criteria for Qualifying Child listed above.
- 4) If you enroll a Domestic Partner in medical or dental coverage, IRS regulations require that Gallagher’s contribution toward the cost of your domestic partner’s coverage will be included in your income on Form W-2 and taxed for any applicable federal, FICA, state, local, or other payroll taxes. If your domestic partner meets the criteria for Qualifying Relative listed above, this imputed income tax effect will not apply.
- 5) Current federal regulations also require that your contributions and/or premiums for domestic partner coverage be made on an after-tax basis unless you certify that your domestic partner qualifies as a tax dependent under IRC Section 152.

For more information about the criteria required for tax dependent status, please send an email to [HRSupport@ajg.com](mailto:HRSupport@ajg.com).

For US Employees

## Arthur J. Gallagher & Co. Employee Benefit Eligibility - DEPENDENTS

January 1, 2024

### HEALTH BENEFITS

Dependent eligibility is first determined by an individual's relationship to the covered employee. In Gallagher's health plans, legal spouses, domestic partners, and children are all eligible for dependent coverage. Children include biological children, adopted children, stepchildren, eligible foster children, and children of an employee's domestic partner. Generally, dependent eligibility for health plans is based only on relationship and age (for child dependents), except where federal regulations and tax law further restrict eligibility as outlined below:

	Legal Spouse <sup>1</sup>	Domestic Partner <sup>2</sup>	Child <sup>3</sup>	Domestic Partner Child <sup>2</sup>
Medical Plan - PPO+HSA 1	Yes	Yes	Until age 26 Age 26+ if certified disabled and tax dependent	Until age 26 Age 26+ if certified disabled and tax dependent
Medical Plan - PPO+HSA 2	Yes	Yes	Until age 26 Age 26+ if certified disabled and tax dependent	Until age 26 Age 26+ if certified disabled and tax dependent
Medical Plan - PPO+HCA	Yes	Yes	Until age 26 Age 26+ if certified disabled and tax dependent	Until age 26 Age 26+ if certified disabled and tax dependent
Dental - Standard and Enhanced Plan Options	Yes	Yes	Until age 26 Age 26+ if certified disabled and tax dependent	Until age 26 Age 26+ if certified disabled and tax dependent
Vision Plan	Yes	Yes	Until age 26 Age 26+ if certified disabled and tax dependent	Until age 26 Age 26+ if certified disabled and tax dependent
Health Savings Account	Yes	Tax dependents only	Tax dependents only	Tax dependents only
Health Care Account (embedded feature of the PPO+HCA medical plan)	Yes	Yes	Until age 26 Age 26+ if certified disabled and tax dependent	Until age 26 Age 26+ if certified disabled and tax dependent
Health Care Flexible Spending Account Plan	Yes	Tax dependents only	Until age 26	Until age 26
Dependent Day Care Flexible Spending Account Plan	No	No	Until age 13, tax dependents only	Until age 13, tax dependents only

### LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Dependent eligibility for life insurance and AD&D benefits is also determined by an individual's relationship to the covered employee. In Gallagher's life insurance/AD&D plans, legal spouses, domestic partners, and children are all eligible for dependent coverage. Children include biological children, adopted children, stepchildren, eligible foster children, and children of an employee's domestic partner. However, eligibility for children is limited to those who meet the criteria for tax dependents as shown below:

	Spouse <sup>1</sup>	Domestic Partner <sup>2</sup>	Child <sup>3</sup>	Domestic Partner Child <sup>2</sup>
Company-Provided Life/AD&D Insurance (Dependent Coverage)	Yes	Yes	Until age 19 (all children)/age 19-25 (children who are full-time students and tax dependents)	Until age 19 (all children)/age 19-25 (children who are full-time students and tax dependents)
Group Universal Life Insurance	Yes	Yes	Until age 19 (all children)/age 19-25 (children who are full-time students and tax dependents)	Until age 19 (all children)/age 19-25 (children who are full-time students and tax dependents)
Accidental Death & Dismemberment Insurance	Yes	Yes	Until age 19 (all children)/age 19-25 (children who are full-time students and tax dependents)	Until age 19 (all children)/age 19-25 (children who are full-time students and tax dependents)

### ACCIDENT, CRITICAL ILLNESS, HOSPITAL INDEMNITY, IDENTITY PROTECTION AND LEGAL SERVICES

Dependent eligibility for voluntary benefits is determined by an individual's relationship to the covered employee. In Gallagher's voluntary benefit plans, legal spouses, domestic partners, and children are all eligible for dependent coverage. Children include biological children, adopted children, stepchildren, eligible foster children, and children of an employee's domestic partner. However, eligibility for children is limited to those who meet the criteria for tax dependents as shown below:

	Spouse <sup>1</sup>	Domestic Partner <sup>2</sup>	Child <sup>3</sup>	Domestic Partner Child <sup>2</sup>
Accident, Critical Illness, Hospital Indemnity Insurance	Yes	Yes	Until age 26	Until age 26
Identity Protection Program	Yes	Yes	No age limits for child coverage so long as the child still lives at the same address or is financially dependent on the employee	No age limits for child coverage so long as the child still lives at the same address or is financially dependent on the employee
Legal Services Plan	Yes	Yes	Until age 26 Age 26+ if certified disabled and tax dependent	Until age 26 Age 26+ if certified disabled and tax dependent

<sup>1</sup>legal spouses are defined by the state in which the marriage took place.

<sup>2</sup>please consult the Arthur J. Gallagher & Co. Domestic Partner Policy for a definition of eligible domestic partner and income tax implications of domestic partner enrollments.

<sup>3</sup>includes Adopted Child, Step Child, Eligible Foster Child, and Child of a Domestic Partner