Ingredion Inc.
Retirement Health Care Spending Accounts
Benefit Election Form

This form must be signed no later than 30 days after the employees last day worked or coverage under the Plan will be deemed to have been waived.

A. Personal Data

Name:________________________________ Social Security Number:_______________________

Date of Birth:__________________________ Telephone Number:___________________________

Last Day Worked:______________________

Address:____

____

B. Retirement Health Care Spending Account Coverage Election

☐ I elect coverage for myself and my eligible dependents.

☐ I elect coverage for myself only. I understand that I am giving up access to a Retirement Health Care Spending Account for my eligible dependents (if any). I further understand that, except as discussed in item F below, I cannot elect dependent coverage at a later date.

☐ I elect coverage for my eligible dependents only. I understand that I am giving up access to a Retirement Health Care Spending Account for myself. I further understand that, except as discussed in item F below, I cannot elect coverage for myself at a later date.

☐ I waive coverage under the Plan. I understand that I am giving up both of my Retirement Health Care Spending Accounts. I further understand that, except as discussed in item F below, I cannot elect coverage for myself or my eligible dependents (if any) at a later date.

C. Dependent Information

1. Name:________________________________ Social Security Number:____________________

   Date of Birth:___________________ Sex:_________ Relationship:________________________

2. Name:________________________________ Social Security Number:____________________

   Date of Birth:___________________ Sex:_________ Relationship:________________________

3. Name:________________________________ Social Security Number:____________________

   Date of Birth:___________________ Sex:_________ Relationship:________________________

4. Name:________________________________ Social Security Number:____________________

   Date of Birth:___________________ Sex:_________ Relationship:________________________

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D. Medical and Dental Plan Election

Complete this section only if employee or dependents are not Medicare eligible at employee's retirement.

Check the medical and dental plan option and coverage level you wish to elect. This coverage will be effective for the remainder of the calendar year. You may change your medical and dental plans annually during Open Enrollment. Please refer to the RHCSA Rate Sheet for the costs of each option.

If you have exhausted your account balances, you will be billed annually in advance for the remaining cost of coverage of the medical and dental care options chosen. You will have a 60-day grace period to make this payment to Ingredion Inc., after which health care coverage will be terminated if payment is not received. If your health care coverage is terminated due to nonpayment of premium, evidence of insurability may be required before coverage can be reinstated.

1. Medical Plan:

Coverage Option: ☐ HRP ☐ HSP

Coverage Level: *If employee is not Medicare eligible, choose one of the options shown below.*

☐ Employee ☐ EE+Child(ren) ☐ EE+Spouse ☐ Family

If employee is Medicare eligible, choose one of the options shown below.

☐ Spouse ☐ Child(ren) ☐ Family

2. Dental Plan:

Coverage Option: ☐ PDO

Coverage Level: *If employee is not Medicare eligible, choose one of the options shown below.*

☐ Employee ☐ EE+Child(ren) ☐ EE+Spouse ☐ Family

If employee is Medicare eligible, choose one of the options shown below.

☐ Spouse ☐ Child(ren) ☐ Family

E. Private Insurance Election[1]

Coverage Option: ☐ Private Insurance - Waive Ingredion-Sponsored Plans

Ingredion is offering our pre-65 retirees and their eligible dependents (must be declared in Section C) the opportunity to purchase a private **(no employer sponsored or COBRA plans)** medical, prescription drug and/or dental plan outside of Ingredion's plans and seek full reimbursement[2] from their Retirement Care Health Spending Accounts. **A Retiree who has opted out of the Ingredion-sponsored plan(s) shall not be eligible to enroll in an Ingredion plan, for retiree coverage, at any point in the future.**

E. Private Insurance Election[1] Continued

Reimbursement requests must include sufficient documentation as detailed below. Ingredion has established two set submission / reimbursement payment windows:

Submission Deadline*	Reimbursement Payment
June 30	Month of July
November 15	Month of December

*We will not honor any reimbursement requests submitted after the submission deadlines

You must provide proof of your expenses paid and period of coverage (which must be a bill, invoice or statement showing the cost of your premium) and the dependents covered. Please note that canceled checks alone are not considered receipts or proof of payment. All RHCSA reimbursement requests should be submitted to Ingredion via email at: rhcsa@ingredion.com. Please ensure you include "RHCSA – Your Name" in the subject line. Reimbursement requests may still be submitted by physical mail:

Ingredion Tulsa Shared Service Center
C/O RHCSA Reimbursements
810 S Cincinnati
Floor 4
Tulsa, OK 74119

[1]A retiree that receives a Severance Premium Subsidy must remain on the Ingredion-Sponsored Plan(s) and is not eligible to elect Private Insurance until the subsidy period has expired. A retiree eligible employee, approved for LTD, must remain on the Ingredion-Sponsored Plan(s) and is not eligible to elect Private Insurance.

[2] Full reimbursement is available until the earlier to occur of (1) the date on which such account has been depleted or (2) the Retiree attains age 65.

F. Signature

I certify that I have read and understand the information contained on this form. I further understand that, subject to the Plan rules, I may revoke this election by filing a new benefit election form with the Company at any time prior to the later of 30 days after the receipt of this form or my last day worked.

By electing the Private Insurance option and signing this form I acknowledge that I have reviewed the details and are waiving coverage under the Ingredion-sponsored plans. It is further understood that my decision is irrevocable and a retiree and/or eligible dependent that has opted out of the Ingredion-sponsored plan(s) shall not be eligible to enroll in an Ingredion plan, for retiree coverage, at any point in the future.

Employee Signature:____ Date:____________________