Employee Assistance Application Form

AZZ CARES FOUNDATION

I. General Information.

Date

Name of Applicant

Home Address (Street)

(City) (Zip or Postal Code)

Telephone Number(s)

Name of Employee (if not Applicant) / Applicant's Relationship to Employee

Employee Number (Or Social Security Number if not Employee)

Applicant's Employer

Work Address (Street)

(City) (Zip or Postal Code)

Applicant's Occupation/Title

Annual Gross Household Income Prior to Event Requiring Assistance

Annual Gross Household Income Following Event Requiring Assistance

Number of Dependents (excluding Applicant) | Ages of Dependents

If Employee Assistance Application Form indicates that any amounts requested are covered by insurance, indicate reason that additional relief is warranted:

Relief Requested:

Reason for Relief:

II. Certification Of Lost/Unavailable Documentation. (If applicable)

I hereby certify the following (check all boxes that apply):

☐ I have attached supporting documentation to this Application, if available.

☐ I do not have access to [all] / [some] supporting documentation. The supporting documentation is not in my possession due to the damage sustained as a result of:

I agree to make my best reasonable efforts to obtain copies of such missing documentation from other sources and submit such copies to the AZZ Cares Foundation if and when obtained.

Date:

Applicant's Signature

Print Name

*** AZZ Cares Foundation shall not obtain any information that would constitute "protected health information," as such term is defined in 45 CFR 160.103, from AZZ Inc. and its subsidiaries (the "Employers") or any group health plan sponsored or maintained by an Employer.*