CLAIM FORM

FILING DEADLINE: August 26, 2020

Name: _____

Mailing Address: _____

_____

_____

Email Address: _____ Telephone Number: _____

To be eligible to receive compensation, you must complete and submit the below. Both sections A and B must be completed.

If you have questions about completing this Claim Form, please go to www.StarbucksAODClaim.com, email info@StarbucksAODClaim.com or call (833) 649-0906.

Please use additional sheets of paper if necessary and attach any relevant documents. The Claim Form may be submitted via the online Claim Portal or mailed to Starbucks AOD Administrator, 1650 Arch Street, Suite 2210, Philadelphia, PA 19103.

A. **Please provide documentary evidence and/or a narrative description of the time(s) you believe you (1) were required to find a replacement in order to use sick leave, or (2) were disciplined for not finding a replacement in connection with the use of sick leave.**

B. Please provide the following information regarding your claim(s). Sections 1 and 2, and *either* 3 or 4 must be completed.

1. Store Location(s)

   i. _____
   _____

   ii. _____
   _____

   iii. _____
   _____

2. Approximate Date(s) and Purpose(s) of Usage

   i. _____
   _____

   ii. _____
   _____

   iii. _____
   _____

3. Manager(s) or Supervisor(s) Contacted Regarding the Usage

   i. _____
   _____

   ii. _____
   _____

   iii. _____
   _____

4. Potential Substitute Employee(s) Contacted Regarding the Usage

   i. _____
   _____

   ii. _____
   _____

   iii. _____
   _____

<u>You must sign and date your Claim Form below in order to be eligible to receive compensation.</u>

I hereby declare under penalty of perjury that the information and facts I have stated in this Claim Form, and any additional pages included, are true and accurate to the best of my personal knowledge.

I certify that I am not subject to backup withholding under the provisions of Section 3406(a)(1)(C) of the Internal Revenue Code.

Note: If you have been notified by the Internal Revenue Service that you are subject to backup withholding, please strike out the language that you are not subject to backup withholding in the certification above.

Signature: _____ Date: _____

_____ _____ _____ _____
Last 4 Digits of Social Security Number (Required for Verification Purposes)

Submit this Claim Form online at www.StarbucksAODClaim.com by August 26, 2020, or mail this completed form along with any extra pages or supporting documentation, postmarked by August 26, 2020, to the address below.

Starbucks AOD Administrator,
1650 Arch Street, Suite 2210
Philadelphia, PA 19103