Affidavit of Same Gender Partnerships

I, _____ , submit this Affidavit of same gender Domestic Partnership to establish
(*Name of Employee)*

_____ as my same gender Domestic Partner ("Partner" as defined below)
(*Name of Domestic Partner)*

for the purpose of obtaining health & welfare benefits[1] under Veolia North America Health and Welfare Benefits Plan (the "Plan") Domestic Partner Policy.

1. I declare that my same gender Partner is eligible for benefits because (you must check one of these):

☐ We have registered as domestic partners in _____ (state or municipality where registered); ***or***

☐ We meet all of the following criteria:

- The employee and the Partner *must have continuously resided* together for a minimum of twelve (12) months and intend to do so permanently.
- The employee and the Partner *cannot be related* by blood to a degree of closeness that would prohibit a legal marriage.
- The employee and the Partner are *mutually responsible* for the basic living expenses.
- Both the employee and the Partner are at least the *age of consent* in the state in which they reside.
- *Neither* the employee nor the Partner is *legally married* to someone else. If you or your Partner has been married and do not yet have a final divorce decree, you are not eligible for this benefit at this time. You may apply when the final divorce papers are received.
- Neither the employee nor the Partner has another Partner.
- The employee and the Partner are of the same-gender.

2. I agree to notify the Veolia Benefits Center at 1-844-690-0918 within **thirty-one (31)** days of any change in the circumstances attested to in this Affidavit by completing an Affidavit of Termination of same gender Domestic Partnership.

3. I understand I may be responsible for payment of income taxes as a result of the Plan providing benefits to my Partner (and his or her children, if applicable).

4. If requested, I will provide to the Plan Administrator or designated representative**,** documents to verify my Partner's eligibility and compliance with Federal and State law.

5. I understand that providing false or misleading information in the Affidavit may result in any or all of the following actions: termination of Plan coverage, a requirement that I reimburse the Plan for all expenses and/or other legal action brought against me.

I affirm that the assertions in this Affidavit are true to the best of my knowledge.

_____ _____

Signature of Employee Date

[1] For purposes of this declaration, "benefits" includes, but is not limited to, medical, dental and vision insurance. Employees can also seek pre-tax reimbursement through their flexible spending account or health savings account for medical expenses incurred by qualifying tax dependents (which may or may not include your domestic partner/civil union partner).