Affidavit of Domestic Partnership

New Enrollment ☐ Status Change Only ☐

I,_____(Employee Name), submit this Affidavit

of Domestic Partnership to establish _____(Domestic Partner Name) as my domestic partner, as defined below, for the purpose of obtaining benefits that Veolia* extends to domestic partners of employees.

1. I declare and acknowledge that my domestic partner and I meet on of the following criteria:
   - ☐ We are registered as domestic partners with a municipality that has such registration, and I have attached the registration, or
   - ☐ We meet all of the following conditions:
     - We are both at least 18 years of age.
     - Neither of us is legally married or in a domestic partnership with another person.
     - We are not related by blood to a degree of closeness that would prohibit marriage.
     - We currently reside together and we intend to do so permanently.
     - We are mutually responsible for the basic necessities of life.
     - We are in a committed relationship that is intended to be permanent.
     - My partner is not eligible for Medicare.
     - My partner is not otherwise enrolled in a Veolia* plan as an employee or dependent.
2. I agree to notify Human Resources if there is any change of circumstances attested to in this Affidavit within 31 days of the change by filing an Affidavit of Termination of Domestic Partnership. Such Affidavit will affirm that the partnership is terminated and that, unless my domestic partner has died, a copy of the Affidavit of Termination of Domestic Partnership has been mailed to my domestic partner.
3. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed until 12 months have passed.
4. I understand that I may be responsible for payment of income taxes as a result of the Company providing health benefits to my domestic partner. (Refer to the reverse side of this Affidavit for details.)
5. If requested, I will provide to the Plan Administrator or designated representative documents verifying our Domestic Partnership, such as a joint mortgage lease, statement of joint assets such as a bank account, or designation of one as beneficiary or executor by the other.
6. I understand that providing false or misleading information in the Affidavit may result in any or all of the following actions by the Company: a requirement that I reimburse the Company for all expenses; termination of my employment; and other legal action against me.
7. If I am enrolling my domestic partner's children, I declare and acknowledge that they meet the following criteria:
   - The child lives with me;
   - The child is unmarried;
   - The child is younger than age 26
   - The child is not otherwise enrolled in a company plan as an employee or dependent; or
   - The child is over age 26, was enrolled in the plan before age 26, and became mentally or physically handicapped before age 26.

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

_____	_____	_____
Signature of Employee	Employee ID Number	Date

You must submit the *Affidavit of Domestic Partnership* along with the *Tax Status* and *Dependent Data* form as soon as possible but no later than 31 days after date of hire or qualifying event. This completed form should be uploaded to the Benefit Enrollment site. If you have any questions, please contact the Veolia Benefits Center at (844) 690-0918.

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Tax Status and Dependent Data

You should consult with a tax advisor before you certify that your domestic partner is your dependent as defined in section 152 of the Internal Revenue Code. Keep in mind that if your domestic partner and his or her children do **not** meet the Internal Revenue Code definition of a tax dependent:

- You may not make pre-tax contributions for his or her health care coverage, and
- The Company-paid portion of any medical and dental coverage for you domestic partner (and his or her children) will be reported as taxable income to you, as required by law. This additional taxable income will be reflected on your W2 and additional taxes will be withheld from your paycheck.
- You cannot use your FSA or HSA to pay for your domestic partner's (and his or her children's) unreimbursed health care or dental expenses.

Employee Information

Employee Name	Employee ID Number

Dependent Information (Please list your domestic partner and his or her children who you wish to enroll in Veolia* Benefits)

	Name	DOB	Gender
Domestic Partner:			
Child(ren):			

Tax Status

For the purposes of this plan, I declare that my domestic partner

- ☐ Is my dependent for tax purposes.
- ☐ Is not my dependent for tax purposes.

If I am also covering my domestic partner's children, I declare that the child(ren) listed above

- ☐ Is (are) my dependent for tax purposes.
- ☐ Is (are) not my dependent for tax purposes.

I understand that if I had previously certified my domestic partner and/or his or her child(ren) as a tax dependent, I may be liable for taxes due to changing the tax status.

_____ _____

Signature of Employee Date