Affidavit of Domestic Partnership

Please read the domestic partner eligibility requirements below for information and requirements for enrolling a domestic partner and/or his or her dependent children. Complete the applicable sections below to enroll a qualified domestic partner and/or children of a domestic partner in the Engility medical, dental, and/or vision plan options in which you are enrolled. Legal restrictions do not allow you to change your benefit selection until the open enrollment period or if you experience a qualified life event.

1. Domestic Partner:

A. ___(Employee initials here) I certify that my domestic partner meets all of the following conditions

- Is my life partner who has lived with me in the same permanent residence in an exclusive, emotionally committed, and financially responsible relationship similar to a marriage for at least 6 months (or is registered as your domestic partner in a state where registration is available)
- Is at least 18 years of age and is not related to me by blood
- Is not married to anyone else and is not the domestic partner of anyone else
- Is my sole domestic partner and intends to remain so indefinitely.

B. Date Domestic Partnership established:_____Name:_____
(Domestic Partner)

C. I☐*have* ☐ *have not* filed a registration, certification, or declaration of domestic partnership with a state or municipal authority. (If yes, please provide a copy of your filed paperwork.)

2. Domestic Partner's Children:

Children of a domestic partner who meet the eligibility requirements listed below may also be enrolled. *Note: Children you have adopted or for whom you have legal guardianship and who meet the definition of an eligible dependent may be enrolled as your child (which is more favorable from a tax treatment standpoint) and should not be enrolled using this form.*

____*(Employee initials here)* I certify that the child(ren) -- who must be under age 26 and meet(s) the requirements of an eligible child under the Engility Health Plan, including:

- Living with me in a parent/child relationship, meet the requirements of an eligible Domestic Partner's children.

3. Enrollment: (Please Print)

Employee Name *(First, Last):*				**SSN**:			
Coverage Elections: In the chart below, please provide the requested domestic dependent information and indicate which coverage (medical, dental, and/or vision) you want to select for each domestic dependent.							
Domestic Partner/ Child Name ***(First, Last)***	**SSN**	**Relationship** ***DP*** *(Domestic Partner)* ***DPC****(Domestic Partner Child under age 26)*	**Gender** *(Male or Female)*	**Date of Birth**	**Medical**	**Dental**	**Vision**

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4. Employee Certification:

I understand that under federal and state income tax laws, unless the requirements for dependent status are satisfied, payment for health coverage for a domestic partner and children of a domestic partner is not eligible for favorable tax treatment, and their enrollment may result in additional taxable income for federal and state/local income tax and Social Security payroll tax withholding purposes. I acknowledge that:

- I cannot file another Engility Affidavit of Domestic Partnership for a new domestic partner until at least six months after a Statement of Disenrollment, Death or Termination of Domestic Partnership has been filed
- If requested, I will provide documents establishing the existence of my domestic partnership relationship
- Engility is not providing legal or tax advice and I have been advised to consult an attorney or tax advisor regarding the possible legal or tax implications of filing Engility Affidavit of Domestic Partnership
- I have an obligation to file a Statement of Disenrollment, Death or Termination of Domestic Partnership with the Engility Benefits Service Center within 60 days of the earliest of (a) the death of my domestic partner or (b) the date on which any of the criteria of a domestic partnership relationship is no longer met. I further understand that the effective date of the end of the domestic partnership relationship is the earliest of (a) the death of my domestic partner, (b) the date on which I file a Statement Disenrollment, Death or Termination of Domestic Partnership with the Service Center, (c) the date on which the domestic partner notifies the Plan of the termination of the domestic partnership or (d) the date on which one or more of the criteria of domestic partnership are no longer met
- I understand that I am responsible for the reimbursement of any expense incurred as a result of any false or misleading statement contained in this Engility Affidavit of Domestic Partnership, including any claims paid under any benefit plans in which I enroll my domestic partner and/or children of my domestic partner. The Plan shall have the right to recover attorney fees and costs incurred in collecting such expenses from me.

I certify that I am not married to anyone else and that the information I have provided is correct, and I understand that providing false, incomplete, or misleading information may result in termination of benefits

Employee Signature _____ Date _____

Return Completed Form To: Engility Benefits Service Center P. O. Box 563919 Charlotte, NC 28256-3919 Fax: 847-554-1739

ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of _____, County of _____

On _____ before me, _____

Date (mm/dd/yyyy) Name of Notary

personally appeared _____, personally known to me or (proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrucment the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

Witness my hand and official seal. Notary Seal

_____ _____ _____

Signature of Notary Position Title Date (mm/dd/yyyy)

_____

Print Name