Brookhaven National Laboratory

AFFIDAVIT OF DOMESTIC PARTNERSHIP

Declaration of Domestic Partnership

We, the undersigned Employee, Retiree, or Long Term Disability Plan recipient (herein referred to as "Participant") and their Domestic Partner certify and declare that we are domestic partners in accordance with the criteria set forth in the Brookhaven Science Associates, LLC. (BSA) benefit plans regarding coverage of domestic partners and are eligible for benefits through BSA's benefit programs. Specifically, we meet the conditions of either A. or B. below:

A. We have registered our domestic partnership with a governmental body, to the extent such registration is available where we are domiciled and have not revoked such registration.

B. We are in a committed long-term relationship with each other such that we:
   - Are at least age 18 and otherwise legally competent
   - Have cohabitated for at least 6 months in a monogamous relationship
   - Are not married to anyone else (even if legally separated)
   - Are not related by blood
   - Are jointly responsible for financial obligations

We understand that dependent children of the domestic partner are eligible for certain BSA benefit coverages when they are:

- Unmarried,
- Primarily dependent on the Participant or domestic partner for financial support,
- Living with us (unless waived due to student status as discussed in the applicable benefits plan), and
- Meet any age, student status, or incapacity requirements described in the applicable benefit plan.

Acknowledgement of Tax Implications

We acknowledge the individual(s) below is covered under a healthcare plan sponsored by BSA, the Participant's share of the cost of that coverage must be paid on an after-tax basis and the Participant's share of the cost of coverage of that individual is taxable income to the Participant, and subject to appropriate federal income tax withholding and payroll taxes, if applicable, and such an individual's benefit expenses may not be reimbursed from the reimbursement accounts.

We understand there may be other requirements as well. We understand that the state income tax and withholding consequences related to benefits coverage for a domestic partner and/or child of a domestic partner may be different than the consequences under federal tax rules. You should consult with your personal tax advisor regarding whether an individual can be treated as a "dependent" for federal tax purposes.

Name:	_____	Relationship:	Domestic Partner
Name:	_____	Relationship:	Child of Domestic Partner
Name:	_____	Relationship:	Child of Domestic Partner
Name:	_____	Relationship:	Child of Domestic Partner

Commitment to Notify Regarding Change in Domestic Partnership

We agree to notify BSA if there is any change in our status as domestic partners as attested in this Affidavit which would make the non-Participant partner and/or any of his/her dependent children ineligible for BSA's benefit plans (for example, due to the death of partner, a change in joint-residence, termination of the relationship, material change in financial dependence or interdependence, etc.).

The Participant agrees he or she will notify BSA within thirty-one (31) days of a change in the status as domestic partners by filing an Affidavit of Termination of Domestic Partnership (Affidavit of Termination). The Affidavit of

Termination shall be on a form provided by BSA. The Participant agrees to promptly mail a copy of the Affidavit of Termination to the last known address of the former domestic partner (unless the partner is deceased).

If a change occurs whereby the domestic partnership is not terminated, but a child of a domestic partner no longer qualifies for coverage under the requirements set forth above, we agree to notify BSA within thirty-one (31) days of such change and understand that the termination of such dependent's coverage will occur at the time provided in the applicable health plan for other similarly situated dependents who experience a loss of eligibility.

We understand that termination of coverage for domestic partners (and, in some cases, termination of coverage for children of domestic partners) is not a qualifying event for purpose of continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) unless the domestic partner or dependent otherwise is a qualified beneficiary under COBRA. We further understand that some sort of continuation coverage nevertheless may be provided under some of BSA's benefit programs at the sole discretion of BSA and/or a third-party insurer.

Other Acknowledgments

We understand that any person or entity who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us jointly and severally to recover their losses, including reasonable attorney's fees, and that falsification may result in immediate loss of coverage (loss of coverage may be retroactive in some cases), as well as disciplinary action against the Participant.

We understand that BSA reserves the right to request supporting documentation and any other proof as it, in its sole discretion, deems necessary in order to verify the representations we have made in this Affidavit, and we agree to make reasonable and diligent efforts to provide the requested information to BSA in a timely and complete fashion. We further understand that BSA reserves the right to require us to verify this Affidavit (or complete another Affidavit) on an annual or otherwise periodic basis.

We understand that this Affidavit may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Affidavit, we should seek competent legal, accounting, and tax advice concerning such matters.

We understand the potential federal and state tax implications of coverage supplied to domestic partners and children of domestic partners.

We declare, under penalty of perjury, under the laws of the State of _____ that the assertions in this Affidavit are true to the best of our knowledge. We understand that this form is not an application for benefits coverage and that the purpose of this form is to establish the eligibility of persons named herein for the coverage provided under BSA's health insurance programs, and to facilitate BSA's proper administration related to such coverage.

_____	_____	_____	_____
Participant Name (Print)	**Participant Signature**	**Life #**	**Date**

_____	_____	_____
Domestic Partner Name (Print)	**Domestic Partner Signature**	**Date**

Sworn to me this _____ day of _____, 20_____.

_____
Notary Public

09/26/2023