

**Affidavit of Qualifying Domestic Partnership
for Eligibility for Health Plan Coverage**

INSTRUCTIONS:

Your completed Affidavit should be mailed to the SPE Benefits Center at P.O. Box 617907, Chicago, IL, 60661 along with a copy of the following documents demonstrating your joint residency and financial interdependence, unless you are providing proof of registration of your qualifying domestic partnership with a government agency:

- Your drivers' licenses, joint mortgage or lease agreement, rental agreement, or other proof of joint residency; and
- A joint bank account or other proof of financial interdependence.

IMPORTANT NOTE: *You are urged to seek appropriate advice before signing this Qualifying Domestic Partner Affidavit. There may be other implications to signing this document under the laws of the state in which you reside or other applicable law. This Qualifying Domestic Partner Affidavit is not a substitute for, and not intended to be, an affidavit or statement of common law marriage.*

I. DECLARATION

We, _____ and _____,
(Print SPE Employee's Name) (Print Qualifying Domestic Partner's Name)

declare that we are Qualifying Domestic Partners in accordance with the following criteria, and have continually fulfilled such criteria during the immediately preceding six months. In addition to signing and notarizing this affidavit we are providing the required documentation. We understand that Sony Pictures Entertainment "(SPE)" may reasonably request, as necessary, any other documentation which SPE believes is necessary to establish the validity of our domestic partnership.

II. CRITERIA

These criteria must all be met:

Domestic Partner shall mean an individual to whom the Eligible Employee is not legally married or has not entered into a lawful civil union in the state, if applicable, where he or she resides, and who meets and can attest to the following requirements:

- a) You are registered as domestic partners or have entered into a lawful civil union within the state, if applicable, where you reside, or
- b)(i) You're each other's sole domestic partner and are emotionally committed to each other for mutual care and support and intend to remain so indefinitely; and
- b)(ii) You have resided together in the same principal residence for a full six months and intend to remain so indefinitely; and
- b)(iii) You're jointly responsible for each other's financial welfare and basic living expenses (you're financially interdependent); and
- b)(iv) You're both at least age 18 and mentally competent to consent to a contract under the laws of the state where you reside; and
- b)(v) You're not related by blood closer than would bar marriage under applicable law in effect where you reside; and
- b)(vi) You're not legally married to each other and you're not legally married or separated from anyone else.

III. CHANGE IN QUALIFYING DOMESTIC PARTNERSHIP STATUS

I, _____, agree to immediately notify SPE Benefits Center
(Print SPE Employee's Name)

if we cease to meet any one or more of the criteria listed in Section II above. We understand that we are obligated to notify the SPE Benefits Center and failure to notify the SPE Benefits Center will not prevent or delay the

termination of eligibility for benefits based on the Qualifying Domestic Partnership. Such termination may be made retroactive, as appropriate.

After such termination, I, _____, understand that a
(Print SPE Employee's Name)

subsequent Qualifying Affidavit of Domestic Partnership cannot be filed until at least six months have elapsed after the effective date of the prior Affidavit of Termination.

IV. ACKNOWLEDGMENT

By signing below, we acknowledge the following:

- * We have provided this information in the Affidavit for the confidential use by SPE for the purpose of determining eligibility for and participation in certain health care benefit plans. This Affidavit applies to all benefit plans that SPE makes available to Qualifying Domestic Partners. We understand and acknowledge that the definition of eligible dependents may vary under the terms of each benefit plan SPE sponsors and that submitting the Affidavit in no way alters any eligibility provision of any benefit plan. We have been advised to refer to each benefit plan for specific details regarding eligibility and benefits.
- * We understand that the value of health care benefits for the Qualifying Domestic Partner and the Qualifying Domestic Partner's eligible children (if any) will be treated as taxable income.
- * The employee cannot file another Qualifying Domestic Partner Affidavit for a new Qualifying Domestic Partner until at least six months has lapsed after an Affidavit of Termination of Qualifying Domestic Partnership has been filed.
- * We have been advised to consult with an appropriate professional advisor (tax advisor, attorney, etc.) regarding the impact of this Qualifying Domestic Partner Affidavit and the coverage provided under the plan. We understand that there may be other implications to signing this document that are not described in any of the plan materials provided to us and that may apply only to our SPE specific set of circumstances.
- * We understand that SPE has no legal obligation to extend continuation coverage to Qualifying Domestic Partners (or their dependent children) but has decided to do so. Any such extended coverage may be eliminated in the future.
- * We understand and agree that we are responsible for reimbursement of any expenses incurred as a result of (1) any false or misleading statements in this Qualifying Domestic Partner Affidavit or in Connection with enrollment; (2) failure to file immediately an Affidavit of Termination of Qualifying Domestic Partnership if any of the criteria for qualifying domestic partnership are not met; (3) failure to notify the SPE Benefits Connection promptly upon an eligible dependent child becoming ineligible for coverage.
- * We affirm, under penalty of perjury, that the information in this Qualifying Domestic Partner Affidavit is true and complete to the best of our knowledge; we acknowledge and agree to the terms stated in this Qualifying Domestic Partner Affidavit; and we understand that any misrepresentation may result in loss of benefits and/or termination of employment. We understand that any termination of benefits may be retroactive as appropriate.

SPE Plan Participant Information

Qualifying Domestic Partner Information

(Print SPE Employee's Name)

(Print Partner's Name) _____
(Partner's Date of Birth)

(SPE Employee's Signature)

(Partner's Signature)

(Date)

(Date)

Sworn to me this _____ day of _____, _____.

(Notary Public Signature and Seal)

Internal Use Only:
Stamp Date Received by SPE Benefits Center

Affidavit of Termination of Qualifying Domestic Partnership

Your completed Qualifying Domestic Partner Affidavit should be mailed to the SPE Benefits Center, P.O. Box 617907, Chicago, IL 60661

I. DECLARATION

I, _____, declare the following:
(Print SPE Employee's Name)

1. I ceased to meet at least one of the criteria needed to maintain a Qualifying Domestic Partnership with _____ effective on _____.
(Print Name of Former Partner) (Date Qualifying Domestic Partnership Ended)
2. I am filing this Affidavit of Termination of Qualifying Domestic Partnership in order to cancel the Affidavit of Qualifying Domestic Partnership filed by me previously with respect to the person named above.
3. I have mailed a copy of this Affidavit of Termination of Qualifying Domestic Partnership to my former Qualifying Domestic Partner at the following address:

(Indicate address to which copy of Qualifying Domestic Partner Affidavit was mailed)

I understand that the effect of filing this Qualifying Domestic Partner Affidavit of Termination is that my qualifying domestic partner (and any of his or her children, if applicable) will no longer be covered under the plan as of the date our qualifying domestic partnership ended. Coverage, therefore, will be terminated retroactive to that date.

I also understand that I cannot file a subsequent Affidavit of Qualifying Domestic Partnership until at least six months have elapsed after the effective date of this Affidavit of Termination.

II. ACKNOWLEDGEMENT

I have provided this information in the Qualifying Domestic Partner Affidavit for use by SPE for the purpose of determining eligibility for and participation in health care plans sponsored by SPE.

I affirm, under penalty of perjury, that the information in this Affidavit is true and complete to the best of my knowledge.

SPE Employee Information

(Print SPE Employee's Name)

(Date)

(Signature)

Internal Use Only:

Stamp date received by SPE Benefits Center: