leidos

DECLARATION OF DOMESTIC PARTNERSHIP

I, ______________________________ submit this Declaration of Domestic Partnership to
PRINT NAME

establish ______________________________ as my Domestic Partner as this term is defined
PRINT NAME

below, for the purpose of qualifying for medical, dental, and/or vision benefits that Leidos may extend to employees in a Domestic Partnership. Specifically, we declare and acknowledge that the individuals identified above meet all of the following criteria:

- We have chosen to share our lives in an intimate and committed relationship
- We are responsible for each other's common welfare and financial obligations
- We have shared the same principal residence for the last twelve months and intend to do so indefinitely
- We are both at least the minimum age of consent in the state where we reside
- We are each other's sole domestic partner and have not signed a Domestic Partner Declaration with any other person within the last twelve months
- Neither of us is married to anyone else
- We are not related by blood closely enough to bar marriage in our state of residence
- We are both mentally competent to consent to this domestic partnership

EMPLOYEE ACKNOWLEDGEMENT:

My signature on this Declaration acknowledges that I have read the Leidos guidelines for Domestic Partner coverage and agree to the terms and conditions noted. I also understand that:

- Post-tax premiums and imputed income tax for domestic partner coverage will be deducted from each paycheck I receive for any benefits that I have elected.
- If requested, I will provide to Leidos' Plan Administrator, or designated representative, documents establishing the existence of my Domestic Partnership.
- I understand that I should consult an attorney regarding the possible legal and/or tax implications of filing this Declaration of Domestic Partnership.
- I understand that I have an obligation to notify Leidos Employee Services within 31 days of the death of my Domestic Partner, or the date on which any of the criteria of a Domestic Partnership is no longer applicable.
- I understand that if I knowingly and willfully submit false or misleading information to Leidos contained in this Domestic Partnership Declaration or fail to immediately notify Leidos that my partner is no longer eligible for coverage, I will be subject to disciplinary action, up to and including termination of employment.

EMPLOYEE ACKNOWLEDGEMENT (CONTINUED):

- I also understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statement contained in this Declaration of Domestic Partnership, including claims paid under any benefit plans in which I enroll my Domestic Partner and/or child(ren) of a Domestic Partner. In addition, the Plan shall have the right to recover attorney fees and costs incurred in collecting such expenses from me.

I declare, under penalty of perjury, that the foregoing is true and correct.

Leidos Employee:	**Domestic Partner:**
PRINT NAME	PRINT NAME
SIGNATURE	SIGNATURE
EMPLOYEE NUMBER	DATE OF DECLARATION

When you receive the request, please provide a copy of your Declaration of Domestic Partnership to the Leidos Dependent Eligibility Verification Team using one of the following delivery methods. Please wait for the verification request letter before submitting this document.

- Submit by fax: 1-877-965-9555
- Submit by USPS: P.O. Box 299106, Lewisville, TX 75029-9106
- Submit online: digital.alight.com/leidos
- If you have questions regarding the Dependent Eligibility Verification process, please call 1-866-851-0731.

On this ______ day of ______________, 20____ before me, the undersigned Notary Public, personally appeared ______________ and ______________, who are known to me or proved to me on the basis of satisfactory evidence to be the persons whose names are subscribed to this document.

NOTARY PUBLIC ______________________________

MY COMMISION EXPIRES ______________________________