Affidavit of Domestic Partnership

I. Employee Name:

II. Domestic Partner Name:

III. Declaration:

We certify that we are domestic partners for purposes of coverage under the SomaLogic Health Plan (the "Plan").

In support of this statement, we certify the following is true:

1. As of the date of this affidavit, we are both at least eighteen years of age and are competent to enter into a contract.

2. We are not currently married to, or in a domestic partnership with, another individual in any jurisdiction.

3. We are not related by blood to a degree of closeness that would prevent legal marriage.

4. We share a common residence and agree to provide evidence, if requested. [Evidence may include driver's license, applicable utility statements, title to property, leases, etc.]

5. We have agreed to be responsible for each other's basic living expenses and agree to provide evidence, if requested. [Evidence may include joint mortgages or leases, joint ownership of automobiles, joint bank accounts, or a will or life insurance policy designating the partner as the employee's primary beneficiary.]

6. We intend to remain the other's sole domestic partner indefinitely.

We have provided the information in this Affidavit for use by SomaLogic Operating Co., Inc. for the sole purpose of determining eligibility for domestic partner benefits under the Plan. We are aware that a change in domestic partnership is relevant to the Plan's provision of benefits. We agree to notify SomaLogic Operating Co., Inc. / Human Resources Benefits department in writing within 30 days if there is any change in our status as domestic partners, including information attested to in this Affidavit which would make us no longer eligible for employee or domestic partner coverage.

Once we provide notice of a change in domestic partner status, we understand that another Affidavit of Domestic Partnership cannot be filed until 6 months after the date of the filing of a written statement of the termination of a prior domestic partnership.

We attest that the above information is true and accurate. We acknowledge and understand that providing false information may result in employment discipline, up to and including discharge. Further, we understand and agree that if SomaLogic Operating Co., Inc., the Plan or an insurer suffers any loss due to any false statement contained in this Affidavit, such party may bring a civil action against either or both of us to recover its losses. We understand and agree that SomaLogic Operating Co., Inc., the Plan or an insurer may (1) terminate coverage of the Employee or Domestic Partner if that individual does not meet the eligibility requirements of the coverage provided by SomaLogic Operating Co., Inc. or the criteria identified in this Affidavit; or (2) rescind our health care coverage back to the effective date of our coverage if SomaLogic Operating Co., Inc., the Plan or an insurer concludes that our representations in this Affidavit constituted fraud or were an intentional misrepresentation of material fact.

Employee

_____

Signature

Date: _____

Domestic Partner

_____

Signature

Date: _____