



## Certification of Domestic Partner's Qualification for Tax-Free Health Coverage

I. **Employee Name:**

II. **Domestic Partner Name:**

III. **Certification:**

I certify that my domestic partner is eligible for tax-free health coverage under the Plan(s).

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

1. I understand I am being asked to provide the following information for SomaLogic to verify my request for tax-free health insurance coverage for my domestic partner under the Plan(s).
2. My domestic partner's coverage under the Plan is eligible for tax-free treatment because my domestic partner is my *Qualifying Relative* (see requirements and required proof below). I understand that it is my responsibility to determine and/or consult with my tax advisor to determine whether my domestic partner is a *Qualifying Relative*.

My domestic partner satisfies all of the following requirements (check all that apply):

- My domestic partner lives with me and is a member of my household.
  - My domestic partner will receive over one-half of his or her financial support from me during the calendar year for which I am requesting tax-free health coverage. The term "support" includes food, shelter, clothing, medical and dental care, education, and the like.
  - My domestic partner is not another individual's *qualifying child* under Internal Revenue Code Section 152(c).
  - My domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.
3. I will notify SomaLogic within 30 calendar days from the date on which any of the following occurs:
    - My domestic partner ceases to live with me;
    - My domestic partner ceases to be a member of my household;
    - My domestic partner ceases to receive over one-half of his or her financial support from me during the calendar year for which I am requesting tax-free health coverage;
    - My domestic partner becomes another individual's qualifying child under Internal Revenue Code Section 152(c).

I have provided the information in this Certification for use by SomaLogic for the sole purpose of determining the proper tax treatment of domestic partner benefits under the Plan. I am aware that if my domestic partner ceases to be my *Qualifying Relative* for purposes of tax-free health coverage, the coverage may be taxable. I understand that, in all cases, SomaLogic does not guarantee any particular tax treatment (at the federal, state or local level) for myself and my domestic partner.

I certify that the above information is true and accurate. I acknowledge and understand that providing false information may result in employment discipline, up to and including discharge. I understand and agree that SomaLogic, the Plan or an insurer may terminate my coverage or my domestic partner's coverage, or rescind our health care coverage back to the effective date of coverage, if SomaLogic, the Plan(s) or an insurer concludes that I committed fraud with respect to this Certification or made intentionally false representations in this Certification, including representations that were true when made but became false due to changing circumstances. Further, I understand and agree that if SomaLogic suffers any loss due to any false statement contained in this Certification, such party may bring a civil action against me to recover its losses.

**Employee**

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_