



American Institute of Physics

Certificate of Domestic Partner

_____ Employee Name	_____ Social Security Number	_____ Date of Hire
_____ Name of Domestic Partner	_____ Social Security Number	
_____ Residential Address and Telephone		

We hereby certify that we are Domestic Partners, as that term is defined below, and that each of the following statements are true:

1. We live together as domestic partners and we intend to so live together indefinitely.
2. We currently reside together at the address shown above and will show proof of residency with a driver's license, mail with current address or other official document.
3. We are each other's sole domestic partner, and intend to remain so indefinitely.
4. We are mutually responsible for each other's common welfare. We will provide proof of common welfare with documentation such as a joint checking account if possible.
5. Neither of us is married.
6. We are each at least 18 years of age (or the age of consent in our state of residence) and are mentally competent to consent to contract.
7. We are not related by blood to an extent that would prohibit legal marriage in our state of residence.

"Domestic Partner" means two adults who are not related by blood, who have lived together continuously for at least one year and plan to do so indefinitely, are mutually responsible for their common welfare, reside at the same address, and maintain no other domestic partnerships or marriage.

We understand that (i) domestic partner coverage is subject to the same rules and limitations as coverage offered to spouses and other dependents under the health care plan(s), in which we enroll and such other rules and regulations as AIP may in its discretion impose, and that such rules and limitations may change from time to time; (ii) we will be able to choose only from among health care plans offered by insurers that have agreed to coverage of domestic partners, and that this may not include all of AIP's health insurance plans; and (iii) AIP reserves the right to modify or terminate health care coverage for domestic partners at any time.

We are aware that, under applicable state and federal tax laws, coverage for a domestic partner and his/her eligible children will result in taxable imputed income to the employee, subject to income tax withholding and applicable payroll tax. We are also aware that the filing of this Statement of Domestic Partner may have other legal consequences, including the fact that it may, in the event of termination of the domestic partner relationship, be regarded as a factor

leading a court to treat the relationship as the equivalent of marriage for the purpose of establishing or dividing community property or for ordering payment for support.

We understand that AIP may require us to submit additional documentation supporting our eligibility for domestic partner coverage, and we agree to submit such evidence if required. We agree to notify AIP within 30 days of a change in any of the circumstances described in the statements set forth above, and understand that any such change may result in the loss of domestic partner coverage.

We hereby certify that we have resided together for a minimum of 12 months and all the statements above are true and correct. We understand that any misrepresentation of the fact can result in the loss of coverage and our liability for expenses incurred under the Plan. We agree to reimburse AIP for all expenses incurred as a result of any false or misleading information we supply.

Employee's Signature

Date

Domestic Partner's Signature

Date