



Certification of Eligibility For Domestic Partner Coverage

Date:	Location code:	Employee Social Security No.:
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We hereby declare and certify that we are domestic partners, as defined below, for the purposes of obtaining any benefits that Cox Enterprises, Inc. may extend to the domestic partner of an employee.

Employee name (please print)	First	MI	Last
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Domestic partner name (please print):	First	MI	Last
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We certify that we:

- Have an exclusive, committed relationship of mutual caring that has lasted at least twelve (12) months or since ___/___/___, and is expected to last indefinitely. (date)
- We share the same principal residence for 12 months and intend to do so indefinitely.
- We are not married to or legally separated from someone else
- We are not related by blood (to a degree of closeness that would prohibit legal marriage in the state in which you reside).

I (the employee) understand and agree that:

- In the event this relationship no longer meets any of the criteria listed above, I must notify my Local Benefits Coordinator of my partner's ineligible status immediately by submitting a notification letter in writing acknowledging the partner's change in status. I am responsible for notifying my domestic partner that his/her coverage is terminated.
- Domestic Partner Coverage terminates on the date:
 - the employee loses eligibility for benefits
 - the employee and Domestic Partner terminate their partnership (i.e. no longer meet the eligibility criteria)
 - the employee dies
 - the partner dies
 - the partner becomes eligible for coverage elsewhere because of a change in his/her employment status and the employee notifies Cox of the desire to terminate the Domestic Partner's post tax coverage.

We (the employee and the domestic partner) understand and agree as follows:

- We have read and fully understand Cox Enterprises, Inc.'s policy on Domestic Partner Benefits.
- Continuation of the Domestic Partner's healthcare coverage is not required by law, but is provided by Cox Enterprises, Inc. in certain circumstances under the terms of the plan. The cost of any such continued coverage is to be borne solely by the employee.
- We have taken independent steps to understand the legal and tax consequences of filing this Certification and obtaining domestic partner benefits and recognize that we, not Cox Enterprises, Inc., will be responsible for any tax and legal consequences thereof.
- This information will be held in confidence and will be subject to disclosure only upon our express written authorization or if otherwise required by law.
- The submission of any false information in connection with this Certification and/or the enrollment for benefits may result in a civil action being brought against us for any losses, including a retroactive loss of coverage and reimbursement of benefit costs and attorneys fees incurred by Cox Enterprises, Inc. Such submission may also subject the employee to disciplinary action, up to and including termination.

We also certify under penalty of perjury, under the laws of the State of _____, that the foregoing is true and correct
(State of Employment)

By my signature, I affirm that the assertions in this certification are true to the best of my knowledge. Further, we certify that we meet the qualifications for Domestic Partner eligibility, and understand that not meeting eligibility requirements constitutes fraud. Such an act will result in disciplinary action as set forth above.

Signature of employee:	Date:
Signature of domestic partner:	Date: