



Return your form to:
 Benefits Administration
 Mailstop: KSOPKR0301-A
 5454 W. 110th St.
 Overland Park, KS 66211
 Fax 1-913-397-3767
 Phone: 1-888-722-4372
 Due Date: _____

DOMESTIC PARTNER CERTIFICATION
 _____ Plan Year
 January 1 - December 31

CenturyLink employees who elect benefits can extend coverage to their domestic partners. I understand that domestic partners are defined under the Benefits Plan as two people of the same or opposite sex in a spouse-like relationship who have met all of the following requirements for the last 12 months. I certify that my domestic partner and I meet the requirements for domestic partner eligibility under the CenturyLink Benefits Plan set forth below:

- We are each other's sole domestic partner and intend to remain so indefinitely;
- We are not related by blood;
- We are not legally married to any other person;
- We are at least 18 years of age and are mentally competent to consent to the domestic partnership; and
- We are financially interdependent and have resided together continuously for at least twelve months before the date next to my signature below and intend to continue to reside together indefinitely.

I understand that children of domestic partners also may be covered if they meet the criteria for an eligible dependent child under the terms of the Benefits Plan.

I acknowledge that value of the coverage provided to my domestic partner (and his or her child(ren)) under the Flexible Benefits Plan will be imputed to me as additional taxable income and will be subject to applicable federal, state and local income taxes and FICA. I understand employee contributions for a domestic partner will be made on "after-tax" basis and that this amount will reduce any imputed income. I understand that the value of coverage will not be imputed to me (or that the imputed amount may be less) if my domestic partner (and his or her child(ren)) are my dependents for federal tax purposes and I complete and return an Affidavit of Dependency Status to the Employee Resource Center.

I agree to immediately notify Benefits Administration at the number identified above if any of the above eligibility requirements are no longer satisfied. In the event of a claim for life insurance or AD&D benefits, I or my heirs/beneficiaries, will be required to provide supporting documentation of the Domestic Partner relationship, in accordance with state regulations.

I understand that if I supply false information in this Certification, submit fraudulent benefit claims, or fail to notify Benefits Administration of any termination of this domestic partnership, the Company may: 1) recover any benefits improperly paid, and 2) initiate disciplinary action which may include termination of my employment. I further understand that any person/employer/company who suffers any loss due to any false statement contained in the documents provided as part of this Certification, any fraudulent benefit claims, or the failure to notify the Company as described above, may bring a civil action against either or both of us to recover their losses, including reasonable attorneys' fees.

I understand that the filing of this Certification may have other legal and/or financial consequences, including the fact that it may be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for purposes of establishing and dividing community property, assigning community debt, and for the payment of support.

I certify that any and all representations that we have made and information that we have provided as part of this Certification as evidence of this domestic partnership are true and accurate.

I agree to indemnify, jointly and severally, the Company and the Administrator of the Flexible Benefits Plan for any expenses or liabilities they incur as a result of any misrepresentations or inaccuracies, whether made knowingly or unknowingly, in this Certification.

DOMESTIC PARTNER INFORMATION

_____ Employee Name (Printed)	_____ Social Security No.	_____ Date of Birth (mm/dd/yyyy)
_____ Domestic Partner Name (Printed)	_____ Social Security No.	_____ Date of Birth (mm/dd/yyyy)

EMPLOYEE CERTIFICATION

_____ Employee Name (Printed)	_____ Social Security No.
_____ Employee Signature	_____ Date

PLEASE MAKE A COPY FOR YOUR RECORDS BEFORE SENDING THE SIGNED
 FORM TO BENEFITS ADMINISTRATION

REV. 10.15.2010