



DOMESTIC PARTNER QUALIFIED STATUS CHANGE FORM

_____ Plan Year
January 1 – December 31

EMPLOYEE NAME _____ **EE NUMBER** _____

Please mark and complete the appropriate section to add or delete a domestic partner and dependents under the CenturyLink Benefits Plan. Please do not use gel ink. **PLEASE MAKE A COPY FOR YOUR RECORDS BEFORE SENDING THE SIGNED FORM TO THE EMPLOYEE RESOURCE CENTER.**

ADD COVERAGE

_____ I want to add my domestic partner and/or dependents under the Benefits Plan. 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 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 certify that my domestic partner and I meet the following 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 set forth below next to my signature below and intend to continue to reside together indefinitely.

I acknowledge that the value of the coverage provided to my domestic partner (and his or her child(ren)) under the 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 the Employee Resource Center at the number identified below 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.

Date of common residence _____ (mm/dd/yyyy)

DROP COVERAGE

_____ I want to delete my domestic partner and/or dependents under the Benefits Plan.

Date the above eligibility requirements no longer satisfied _____
(mm/dd/yyyy)

I understand that if my former domestic partner and any of his or her children lose health coverage under the Flexible Benefits Plan as a result of the termination of my domestic partnership, they will be offered the opportunity to elect health care continuation coverage (i.e., COBRA coverage) under the Plan. A copy of this form will be sent to my former domestic partner who can receive mail at the address below.

