

CONFIDENTIAL

AFFIDAVIT of DOMESTIC PARTNERSHIP for BENEFITS ELIGIBILITY



Declaration

We, _____ and _____
(Print Employee's Name) (Print Partner's Name)

certify that we are domestic partners in accordance with the following criteria:

Criteria

1. We are each other's sole domestic partner and intend to remain so indefinitely.
2. We currently reside together in the same household, have resided together for at least twelve (12) months, and intend to continue to do so indefinitely.
3. We have mutually agreed to be responsible for each other's common welfare, basic living expenses, and financial obligations (debts) to third parties.
4. We are of legal age and mentally competent to consent to contract.
5. We are not married or related by blood to a degree of closeness which would prohibit legal marriage in the state in which we reside.
6. Neither of us has an ex-spouse or former domestic partner who is currently utilizing our health insurance benefits (except under COBRA).
7. It has been at least twelve (12) months since either of us has filed a statement of termination of a previous domestic partnership affidavit.
8. We agree to notify bebe stores, inc. if there is any change of circumstances attested to in this Affidavit within thirty (30) days of change by filing a Statement of Termination of Domestic Partnership. Such termination statement shall be on a form provided by bebe stores, inc. and shall affirm under penalty of perjury that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner.
9. After such termination I, _____ understand that another Affidavit of
(Employee)
Domestic Partnership cannot be filed until twelve (12) months after a statement of termination of the previous partnership has been filed with Human Resources.
10. We understand the employee is responsible for payment of applicable income taxes as a result of bebe stores, inc. providing health benefits to a domestic partner.

11. I understand that I am responsible for reimbursement of any expenses incurred as a result of any false or misleading statements contained in this Affidavit of Domestic Partnership.
12. If requested, I will provide to the Plan Administrator or designated representative documents establishing the existence of my Spousal Equivalency relationship.
13. We provide the information in this Affidavit to be used by bebe stores, inc. for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or pursuant to a court order.

We affirm, under penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge.

Signature of Employee Social Security # Date of Birth Date

Signature of Domestic Partner Social Security # Date of Birth Date

Dependent Children of Domestic Partner

We understand that dependent children of domestic partners are eligible for coverage when they are:

- Unmarried,
- Primarily dependent on the employee or domestic partner for support,
- Meet the age/school requirements of the plan for benefits; and
- May be claimed by the employee or domestic partner as a dependent as defined in IRC Section 152.

Eligible Dependents (please print)

Name of Child: _____ Date of Birth: _____

Social Security #: _____ Sex: _____

Name of Child: _____ Date of Birth: _____

Social Security #: _____ Sex: _____

Name of Child: _____ Date of Birth: _____

Social Security #: _____ Sex: _____