Walgreens

Affidavit of Domestic Partnership

Complete this form to declare your domestic partnership for purposes of coverage under the Walgreens Health and Welfare Plan. Send the completed forms to the Benefits Support Center in one of the following ways:

Upload Online: www.BenefitsSupportCenter.com
Secure Fax: 1-877-965-9555
Mail: Dependent Verification Center
P.O. Box 1401,
Lincolnshire, IL 60069-1401

If you have questions about the verification process, please call the Benefits Support Center at 1-855-564-6153 and the Dependent Verification team will be able to assist you. The Benefits Support Center is available from 8 a.m. to 5 p.m. Central Time, Monday through Friday.

Please Print:

Team Member's Last Name: _____ Team Member's First Name: _____

Employee ID Number: _____ Work Location: _____

Declaration

We, _____ and _____ ,
(*Print Team Member's Name*) (*Print Partner's Name*)

declare that we are Domestic Partners in accordance with the following criteria and have continually fulfilled such criteria during the immediately preceding 6 months.

We affirm that the effective date of this domestic partnership is _____ and that we certify and declare that we are domestic partners in accordance with the following criteria:

Criteria

- We are in a domestic partnership that is eligible for coverage under the health and welfare plans at Walgreens;
- Neither of us is married, legally separated, or involved in another domestic partnership;
- We do and will continue to share the same principal address;
- We both reside in the United States or Puerto Rico;
- We maintain an intimate, committed relationship of mutual caring and support;
- We agree to share, and are both responsible for, basic living expenses (e.g. healthcare, rent or mortgage, utility bills) during our domestic partnership and will permit anyone who is owed these expenses to collect from either partner;
- We are not related by blood to a degree of closeness that would prohibit legal marriage under applicable law in effect in the state where we legally reside.

Change in Domestic Partner Status

I, _____, will notify Walgreens if we cease to meet any one or
(*Print Team Member's Name*)
more of the criteria listed above or in the event of my Domestic Partner's death within 31 days of the event. We agree to notify the Benefits Support Center if there is any change in our status as Domestic Partners, as attested to in this affidavit. This notification must be made within 31 days of the change. Upon termination of a domestic partnership while covered under a Company-sponsored benefit plan, we understand that the domestic partner's coverage will end (subject to continuation rights under COBRA, for certain plans).

Important Tax Implications

Under the law, you are required to be taxed on the value of health benefits provided to a domestic partner (and their covered children) who do not qualify as a tax dependent under Internal Revenue Code Section 152 (d). Due to this requirement, the value your partner's coverage is taxable to you and treated as "imputed income." When you cover your domestic partner (and their covered children) on health benefits, and they are not qualified as your tax dependents, then the full value of this coverage will be included in your pay as taxable wages (even though you do not receive the cash) and federal income tax, FICA, state, and other applicable payroll taxes will be withheld. You will see this imputed income on your paychecks.

Acknowledgement

By signing below, we acknowledge the following:

- We have provided the information in the Affidavit for confidential use by my employer, its agents, assigns, and health care and other benefit vendors for the purpose of determining eligibility for and participation in certain employee benefit plans, programs, and policies sponsored by my employer. This affidavit applies to all benefit plans, programs, and policies that my employer makes available to Domestic Partners.
- We understand that the value of health benefits for the domestic partner (and their covered children) will be treated as income to the participant.
- We affirm, under penalty of perjury, that the information in this Affidavit is true and complete to the best of our knowledge; we acknowledge and agree to the terms stated herein; and we understand that any misrepresentation may result in loss of benefits and/or termination of employment.

Obtaining Domestic Partner benefits and the execution of this Affidavit may have consequences under applicable tax and domestic relations laws and may affect your liability to your domestic partner and to third parties. It is recommended that you consult your personal attorney and/or tax advisor before signing this form.

_____	_____
Print Team Member's Name	*Print Partner's Name*
_____	_____
Team Member's Social Security Number	*Partner's Social Security Number*
_____	_____
Team Member's Signature	*Partner's Signature*
_____	_____
Date	*Date*