Certification of Same-Sex Domestic Partner Tax Dependent Status

I hereby certify that the statements below are true and correct.

1. ___________________________________ is my same-sex domestic partner on the date of this Certification pursuant to the terms of the company's employee benefits plans.

2. I have read the notice entitled "Summary of Tax Treatment of Health Coverage Provided for Domestic Partners," and I have independently determined and understand the requirements for qualifying another person as my federal tax dependent.

3. The above person *[place your initials next to the one line that applies to you]*:

________ qualifies as my federal tax dependent in the current tax year.

or

________ does not qualify as my federal tax dependent in the current tax year.

4. I agree to notify the Plan Administrator of the Company Health and Welfare Plan in writing as soon as possible if there is any change in the above person's status as my tax dependent, including any change that may occur mid-year. I understand that any change in such status may result in the retroactive application of taxes to amounts previously paid during the year.

5. I understand that on the basis of the above statements, the Company will decide whether to treat the above person as my tax dependent for all federal income and employment tax purposes, and that if I fail to complete this Certification or any recertification requested by the Company, then the Company will assume that the person **does not** qualify as my federal tax dependent.

6. I agree to reimburse the Company for any and all taxes, penalties, or other losses (including reasonable attorneys' fees) that the Company may incur as a result of its reliance on this Certification if it is untrue or incorrect in any respect, or if I fail to provide the notice required by paragraph 4 above.

____
Signature

_____________________________________ _____________
Type or Print Name Date