SYSCO
AFFIDAVIT OF DOMESTIC PARTNERSHIP

I _____ submit this Affidavit of Domestic Partnership to establish _____
(Associate Name) *(Domestic Partner's Name)*

as my domestic partner (as those terms are defined below) for the purpose of any health and welfare benefits that Sysco extends to domestic partners.

Specifically, I declare and certify that we meet all following criteria:

- We reside together in a common household, have done so for at least 12 consecutive months immediately preceding the date of this affidavit and intend to do so permanently;
- We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we reside;
- We are mutually responsible for basic living expenses;
- We are both the age of 18 in the state in which we reside;
- Neither of us is married nor currently involved in any other domestic partnership; and
- We are mentally competent to contract into a domestic partnership.

I acknowledge that:

- I cannot file another Affidavit of Domestic Partnership for a new domestic partner until at least six (6) months after any previous Dissolution of Domestic Partnership (QSC) Qualifying Status Change has been finalized with Sysco Benefits.

- I have provided supporting documentation to Sysco Benefits establishing the existence of my partnership relationship. For a child(ren) enrollment, a birth certificate is required. Supporting documentation includes one of the following: a.) proof of a shared utility bill b.) proof of a shared lease or mortgage or c.) a joint bank account statement. *A state or local government issued domestic partnership registration may be submitted in lieu of the supporting documentation.*

- I will complete benefits enrollment within 31 days of filing a QSC (i.e., Start of Domestic Partnership or Loss of Other Coverage).

- I understand that I should consult an attorney regarding the possibility that the filing of this Affidavit of Domestic Partnership may have legal consequences, including the fact that it may, in the event of the termination of the Domestic Partnership relationship, be regarded as a factor in which a court may treat the relationship as the equivalent of marriage for the purpose of establishing and dividing community property, or for ordering payment of support.

- I understand that my partner and their eligible dependents are not considered a legal dependent for tax purposes and the value of this health coverage will be treated as imputed income to me. I am responsible for any tax filings related to this coverage.

- To terminate Domestic Partner coverage, I will notify the Sysco Benefits Center of the (QSC) (i.e., Dissolution of Domestic Partnership or Gain of Other Coverage) within 31 days of the event date. If a change is reported outside this timeframe, an election change will not be allowed.

- I understand that my domestic partner and their eligible dependents may receive continued benefits coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) upon my termination of employment.

- I understand that I am responsible for reimbursement of any expenses incurred as a result of any false

SYSCO
AFFIDAVIT OF DOMESTIC PARTNERSHIP

or misleading statement contained in the Affidavit of Domestic Partnership.

- I understand that if Sysco uncovers any information provided is false then it is a violation of Sysco policy and could lead to termination and perhaps retroactive benefits back to date of Affidavit.

I affirm, under penalty of perjury, that the statements in this Affidavit are true to the best of my knowledge.

_____ _____
(Associate Signature) *(Date)*

_____ _____
(Print Name) *(Address, City, State, Zip)*

Notary Acknowledgement

Subscribed and sworn before me this _____ day of _____, 20__.

State of: _____
County of: _____

Signature of Notary: _____
My Commission Expires: _____

Notary Public Seal: