

Team Member Attestation of Eligibility for Domestic Partner Coverage

I am seeking to enroll my domestic partner identified in the Schedule below in the Company's group health insurance plan. By signing below and enrolling my domestic partner in coverage, I hereby attest that we meet the following eligibility criteria:

1. We share the same principal place of residence.
2. We are each other's sole partner and intend to remain so indefinitely.
3. We are engaged in a committed relationship of mutual caring and support and are jointly responsible for each other's common welfare and financial obligations.
4. Availability of the latest CENOMAR (Certificate of No Marriage) from Philippine Statistics Authority and at least one of the following exist as evidence of joint responsibility:
 - a. Documentation showing proof of joint financial responsibility or economic interdependence (such as shared lease, joint bank account, or ownership of property);
 - OR
 - b. Barangay certification of co-habitation stating that the team member & their domestic partner live in the same address, including the duration of their residence therein.
5. Neither I nor my domestic partner is legally married or in a domestic partnership with another person.
6. Both I and my domestic partner are at least 21 years of age and mentally competent to consent for a contract.
7. If I am enrolling any children of my domestic partner, I am the legal parent (whether natural or by adoption) of such children.

I further acknowledge and agree to the following additional requirements.

1. I am responsible for notifying the Company immediately of any termination of the domestic partnership relationship and/or if any of the eligibility criteria outlined above no longer are fulfilled.
2. I may only enroll a domestic partner for coverage during the renewal period in December or January (i.e., I may not enroll a domestic partner in coverage during a plan year).
3. Any non-disclosure of, or willful misrepresentation regarding, any material fact relevant to eligibility for coverage may result in rejection of claims and termination of coverage with immediate effect, and may also result in termination of employment.

I acknowledge that I have read, understand and agree to the above and that my domestic partner named below satisfies the eligibility criteria for enrollment as a domestic partner in the Company's group health coverage. I am aware that I may be asked to provide supporting documents to prove the relationship with my domestic partner and/or their children.

Team Member's Signature

Date

Team Member's Name

Endorsed by S&P Global APAC Benefits and Wellbeing:


Sharlyne Ang

SCHEDULE

Details of Team Member's Domestic Partner

Full Name of Domestic Partner: _____

Date of Birth of Domestic Partner: _____

Biological Sex of Domestic Partner: _____