S&P Global

Employee 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. Neither I nor my domestic partner is legally married or in a domestic partnership with another person.

5. Both I and my domestic partner are at least 21 years of age and mentally competent to consent for a contract.

6. If I am enrolling any children of my domestic partner, my domestic partner is 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. 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.

_____ _____

Signature Date

_____

Employee Name

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SCHEDULE

Details of Employee's Domestic Partner

Full Name of Domestic Partner: _____

Date of Birth of Domestic Partner: _____

Sex of Domestic Partner: _____