Statement of Domestic Partnership

Please read, complete and sign this form, and return it to your Human Resources Representative.

Part A

I submit this ***Statement of Domestic Partnership*** to establish the eligibility of the person named below as my domestic partner for medical, dental, and vision benefits, and/or voluntary life insurance available through Aristocrat Technologies, Inc.

Employee's Name_____ **Social Security Number**_____

Domestic Partner's Name_____ **Social Security Number**_____

Part B

I acknowledge as follows:

The domestic partner named above and I are each other's sole domestic partner and we have chosen to share one another's lives in an intimate and committed relationship of mutual caring. We are each at least 18 years of age, not legally married or a member of another domestic partnership and we reside in the same household. We are also not related by blood in any way that would prevent us from being married to each other.

In addition, I acknowledge that my domestic partner is eligible for benefits because (you must check one of these):

☐ We have registered as domestic partners or entered into a civil union in _____ [*state or municipality*].

☐ We meet at least two of the following three conditions:

- We have a common or joint ownership of a residence or a lease for a residence with both partners listed as tenants.
- We have at least two of the following:
  - joint ownership of a vehicle;
  - joint ownership of checking;
  - joint ownership of a credit account; or
  - durable power of attorney for health care or financial management.
- My domestic partner is designated as the primary beneficiary for at least one of the following:
  - my life insurance;
  - my retirement benefits; or
  - my will or trust.

Part C

Domestic Partnership—Termination

I understand that I am obligated to file a ***Notice of Termination of Eligibility*** with the plan administrator within 31 days of the earliest of (a) the termination of my domestic partner relationship; (b) the date on which my domestic partner and I no longer meet the criteria for domestic partnership set forth above; or (c) the death of my domestic partner.

Cancel Coverage Effective _____

Signature

I understand that acknowledging my domestic partner relationship in this ***Statement*** may subject me to legal obligations to my domestic partner, taxing authorities, or other third parties, and that I should consult an attorney to learn the extent of those obligations.

I acknowledge that the statements above are true and correct.

_____ _____

Employee's Signature **Date**