

Benefits - Affidavit of Domestic Partnership

Complete and return the **Spouse/Domestic Partner Medical-Rx Insurance Affidavit**, along with this **Affidavit of Domestic Partnership** to Townsquare Media Human Resources: benefits@townsquaremedia.com

Note that the Life Event termination of a [Domestic Partnership, Civil Union, Same-Sex Marriage] must be declared within thirty (30) days of the event.

Today's Date: _____

EMPLOYEE INFORMATION

Last Name	First Name	SSN
Title	Dept.	Hire Date

ENROLLMENT TYPE

- ☐ Declaring [Domestic Partnership, Civil Union, Same-Sex Marriage] Effective Date: _____
- ☐ Termination of [Domestic Partnership, Civil Union, Same-Sex Marriage] Effective Date: _____

I. ELIGIBILITY CRITERIA

The following criteria were established for the purpose of determining coverage eligibility through the Townsquare Media, Inc. group health plan for [Domestic Partnership, Civil Union, Same-Sex Marriage] and their eligible dependent child(ren).

- A. Townsquare Media, Inc. employee is eligible for [Domestic Partnership, Civil Union, Same-Sex Marriage] coverage, if the employee is enrolled in the Townsquare Media, Inc. group health insurance program, has a [Domestic Partnership, Civil Union, Same-Sex Marriage] and shares a primary residence with the individual.
- B. The term "dependent child(ren)," for the purpose of coverage eligibility is defined in the same manner as defined for determining coverage for the dependent children of a spouse.

II. DOCUMENTATION OF A [DOMESTIC PARTNERSHIP, CIVIL UNION, SAME-SEX MARRIAGE]

Townsquare Media, Inc. employee and [Domestic Partnership, Civil Union, Same-Sex Marriage] have an established relationship as indicated in the ELIGIBILITY CRITERIA." This [Domestic Partnership, Civil Union, Same-Sex Marriage] Affidavit (and the *Spouse/Domestic Partner Medical-Rx Insurance Affidavit*) are to be completed and returned to Townsquare Media, Inc. Human Resources. The documentation evidencing financial interdependence that satisfies "Domestic Partner" definition/eligibility criteria below, *does not* need to be provided to the Human Resources Dept., however, the related documents *are to be retained* by the employee and made available on request.

III. DECLARATION OF [DOMESTIC PARTNERSHIP, CIVIL UNION, SAME-SEX MARRIAGE]

For the purpose of establishing eligibility for enrollment in the Townsquare Media, Inc. group health insurance program and for no other purpose, we make the following declaration.

I, _____, an employee of Townsquare Media, Inc., and my [Domestic Partnership, Civil Union, Same-Sex Marriage], _____, hereby declare that:

1. The employee is enrolled in the Townsquare Media, Inc. group health insurance plan for Medical-Rx, Dental, and/or Vision Coverage, or other ancillary voluntary Benefit Plans for which Domestic Partners are eligible;
2. We are at least 18 years of age, and have entered into a [Domestic Partnership, Civil Union, Same-Sex Marriage];
3. Neither of us is married to or legally separated from other person, and neither of us is engaged in another [Domestic Partnership, Civil Union, Same-Sex Marriage] relationship;
4. We share a primary residence in the state of _____ and have done so for at least 12 months; and
5. We are financially interdependent and can, on request, provide Townsquare Media, Inc. Human Resources with at least three (3) of the following documents evidencing such financial interdependence:

- Joint ownership of real property or a common leasehold interest in property;
- Common ownership of an automobile;
- Joint bank account;
- A will which designates the other as Primary Beneficiary;
- A Beneficiary Designation form for a retirement plan or life insurance policy signed and completed to the effect that one Domestic Partner is the Beneficiary of the other.

IV. AVAILABILITY OF DOCUMENTS TO ESTABLISH ELIGIBILITY

By signing this Affidavit, we declare and acknowledge our understanding that Townsquare Media, Inc. reserves the right to request proof that our [Domestic Partnership, Civil Union, Same-Sex Marriage] meet the standards enumerated in **Section I**. For establishing eligibility for enrollment in the health and benefit plans offered by Townsquare Media, Inc, including requesting copies of the documents cited in **Section III**.

V. NOTIFICATION OF CHANGE IN OR TERMINATION OF [DOMESTIC PARTNERSHIP, CIVIL UNION, SAME-SEX MARRIAGE]

We agree that, if this [Domestic Partnership, Civil Union, Same-Sex Marriage] is terminated, we will notify Townsquare Media, Inc. within thirty (30) days of such termination or change by submitting a Life Event request in ExponentHR.

- VI. The employee understands that termination of the Medical-Rx, Dental, and/or Vision Coverage (or other ancillary voluntary Benefit Plans) obtained as a result of this “Affidavit” will be effective through the last day of the month during which the [Domestic Partnership, Civil Union, Same-Sex Marriage] ends or at such time as coverage terminates in accordance with the terms and conditions of applicable policies. Receipt by Townsquare Media, Inc. of a copy Certificate of Termination of Committed Partnership issued or other related document shall be deemed conclusive evidence of the termination of the [Domestic Partnership, Civil Union, Same-Sex Marriage] status for purposes of this benefit.

VII. ACKNOWLEDGEMENTS

1. We understand that the information provided in this Affidavit will be treated as confidential by Townsquare Media, Inc. but will be subject to disclosure:
 - a. Upon the express written authorization of the undersigned employee.
 - b. If otherwise required by law or group health insurance program.
 - c. We understand that this Affidavit may have implication to the taxability of benefits provided. We understand that before signing this Affidavit, that we have been advised to speak with a tax advisor concerning such matter. We acknowledge that Townsquare Media, Inc. provided us with no advice in this regard.
 - d. We affirm that the assertions made herein are true and correct to the best of our knowledge.

VIII. AUTHORIZATION and SIGNATURE

Employee Signature: _____ Date: _____

[Insert Type] Partner Name (Last, First, Middle): _____ DOB: _____

[Insert Type] Partner Signature: _____ Date: _____

NOTORIZATION - FOR ENROLLMENT PURPOSES ONLY

The foregoing instrument was acknowledged before me this date of _____, 20____ by:

_____ and _____ as their own free act and deed.

My Commission Expires: _____

Date: _____ Notary Public: