AECOM

DEPENDENT VERIFICATION CENTER
P.O. BOX 1415
LINCOLNSHIRE, IL 60069-1415

Our records indicate you requested a Domestic Partner affidavit. Please complete the attached form and return it to the Dependent Verification Center for processing.

You may submit your documentation by:

Online Upload: http://www.myAECOMbenefits.com/
Secure Fax: 1-877-965-9555
Mail: Dependent Verification Center, P.O. Box 1401, Lincolnshire, IL 60069-1401

If you have questions about the verification process, please call the Dependent Verification Center at 1-844-779-9567. The Dependent Verification Center is available from 8 a.m. to 8 p.m. Central Time, Monday through Friday.

You can view your audit status, obtain documents and access helpful information at http://www.myAECOMbenefits.com/.

Affidavit of Domestic Partnership Employee Information

Name: _____

Daytime Phone Number: _____

Declaration

We, _____ and _____
(Print Employee's Name) (Print Partner's Name)

declare that we are domestic partners in accordance with the criteria set forth below and are eligible for coverage as domestic partners under AECOM benefits plans.

Status

We declare that:

- We are each other's sole domestic partner and intend to remain so indefinitely;
- We are at least 18 years old and mentally competent to consent to contract;
- We reside together in the same principal residence;
- We are emotionally committed to one another, financially interdependent, and jointly responsible for each other's common welfare;
- We are not related by blood closer than would bar marriage under applicable law in effect where we reside; and
- We are not married under the common law of the state in which we reside.

Change in Domestic Partner Status
We will notify the AECOM Benefits Center within thirty-one 31 days of the end of our Domestic Partner Partner relationship.

Acknowledgements
We have provided the information in this Affidavit for use by AECOM for the sole purpose of determining eligibility for partner benefits.

We affirm that the information in this Affidavit is true and complete to the best of our knowledge; we acknowledge and agree to the terms stated herein; and we understand that any misrepresentation may result in loss of benefits, civil action and/or termination of employment. We understand that we are subject to the same enrollment requirements as all other employees who are covered by, or applying for, AECOM benefits.

Employee Signature _____ Date _____

Domestic Partner Signature_____ Date _____

Notarization

State of _____, County of _____

On this _____ day of _____ in the year _____, before me appeared

_____ and _____
know to me to be the persons whose names are subscribed to this document.

Signature and Seal of Notary Republic