



19975 Victor Parkway  
Livonia, MI 48152  
[www.valassis.com](http://www.valassis.com)  
Tel 734.591.3000

## I. DECLARATION MADE TO VALASSIS COMMUNICATIONS, INC. (“VALASSIS”)

We, and \_\_\_\_\_ and \_\_\_\_\_ certify and declare that we are domestic  
(Associate print name) (Domestic Partner print name)

Partners in accordance with the criteria set forth in II below. We understand that on the basis of the Declaration of Domestic Partnership, the domestic partner identified above may qualify for certain benefits under the Valassis benefits program.

## II. DOMESTIC PARTNER CRITERIA

We hereby certify that we meet each of the following criteria:

1. We are each other’s sole domestic partner as set forth above and intend to remain so indefinitely.
2. Neither of us is currently married or legally separated, and neither of us has any other domestic partner.
3. Neither of us has filed a Termination of Domestic Partnership within the proceeding twelve (12) months.
4. We are at least twenty-one (21) years of age and mentally competent to consent to this declaration.
5. We have continuously resided together in a shared legal residence for at least twelve (12) months.
6. We share a committed and mutually dependent relationship with each other that is similar to that of a married couple, but we have either chosen not to marry or cannot legally marry.
7. We are not related to each other by adoption or blood.
8. We recognize that domestic partner benefits are not provided under all insurance plans and understand that we must meet all eligibility requirements of the particular benefit plan(s) we are requesting.
9. We are jointly responsible for each other’s welfare and for basic living expenses and we have joint bank accounts.
10. If a domestic partner is eligible for group health or dental benefits elsewhere, coverage cannot be provided under the Valassis group health or dental plans.

In addition to meeting all of the criteria above, we meet at least two (2) of the following criteria. Documentation is required:

1. We have joint ownership of our home, or if renting, we are joint parties to the lease.
2. Designation of your partner as primary beneficiary in your will or trust completed by a lawyer.
3. Durable power of attorney designating your partner as the primary person to make medical decisions on your behalf.

## III. CERTIFICATION OF DOMESTIC PARTNER AS DEPENDENT

Please consult a tax advisor before you complete this section, which asks for certification whether your domestic partner is a dependent as defined by the Internal Revenue Code.

Please check one:

- No, my domestic partner does not qualify as my dependent for Federal income tax purposes. I understand I will be taxed on imputed income for the portion of my premiums paid by Valassis for my domestic partner, and my domestic partner cannot participate in the Valassis Flexible Benefit Plan.
- Yes, my domestic partner qualifies as my dependent for Federal income tax purposes.

I understand that on the basis of the above statements, Valassis will consider the above person my dependent for all federal income and employment tax purposes, and as a result any premiums paid by Valassis on behalf of my domestic partner will not be treated as taxable income to me.

I agree to reimburse Valassis for any and all liability including, without limitation, taxes, penalties or losses (including reasonable attorneys’ fees) that Valassis may incur arising out of its reliance on this affidavit if it is untrue in any respect or if I fail to provide the notice required by paragraph IV.



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#### **IV. NOTIFICATION OF ANY CHANGES**

1. We agree to promptly notify Valassis as required by this Section IV if there is ever any change in our status as domestic partners as attested in this Declaration, which would make the domestic partner (and any dependent children) ineligible for the Valassis benefit program.
2. We will notify Valassis within thirty-one (31) days of any such change in our status as domestic partners. Coverage under the Valassis employee benefits program will be terminated as of the end of the month coincident with or next following the date of change in our status as domestic partners.

#### **V. SUPPORTING DOCUMENTATION**

Attached to this declaration are the following documents (or copies thereof):

1. Verification from a bank indicating a joint checking account and/or savings account in the names of the Valassis Associate and the Domestic Partner for the previous twelve (12) months.

And at least two (2) of the following documents:

- Deed to our home in the names of the Valassis Associate and the Domestic Partner or lease to our rental property in the names of the Valassis Associate and the Domestic Partner for the previous twelve months.
- Copy of will with designation of your partner as primary beneficiary.
- Copy of Durable power of attorney designating your partner as the primary person to make medical decisions on your behalf.

#### **VI. ACKNOWLEDGEMENTS**

1. We understand that any person, employer, insurer, or claims administrator who suffers any loss due to any false statement contained in this Declaration may bring civil action, against either or both of us to recover their losses, including reasonable attorneys' fees.
2. We have provided the information in this Declaration for use by Valassis for the sole purpose of determining our eligibility for domestic partner benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization, pursuant to a court order or if there is a compelling business need to have access to the information.
3. We understand that this Declaration may have legal implications relating to our ownership of property or to taxability of benefits provided and that before signing this Declaration, we should seek competent legal and accounting advice concerning such matters.
4. We understand our vendors cannot provide coverage for a domestic partner if the state in which we reside does not allow such coverage. We understand that it is our obligation to determine whether our state of residence allows such coverage.



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We declare, under penalty of perjury, under the laws of the state of \_\_\_\_\_ that the assertions in this Declaration are true and accurate to the best of our knowledge. We understand that this form is not an application for health insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under the "Valassis employee benefits program.

\_\_\_\_\_  
Valassis Associate Signature

\_\_\_\_\_  
Associate SSN

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Domestic Partner Signature

\_\_\_\_\_  
Domestic Partner SSN

Associate/Domestic Partner Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To be completed by the associate and submitted to:

Associate Resource Center (ARC)  
One Targeting Centre  
Windsor, CT 06095