American Airlines

I. Declaration of Domestic Partnership

*I*_____*certify that*_____ *and I are Domestic Partners according to the following policies and are eligible for benefits coverage and travel privileges, as Domestic Partners. Our Domestic Partnership began on*_____. (MM/DD/YYYY Partnership Began)

II. Eligibility Requirements for Domestic Partners

- ❑ Are the same or opposite gender;
- ❑ Reside together in the same permanent residence and have lived in a spouse-like relationship for at least 6 consecutive months (must be able to provide supporting joint financial responsibility for at least 6 consecutive months)
- ❑ Are both at least 18 years of age and are not related by blood to a degree that would bar marriage;
- ❑ Are not legally married or the common-law spouse or Domestic Partner of any other person;
- ❑ Complete a DECLARATION OF DOMESTIC PARTNERSHIP.

III. Declaration of Committed Relationship

In addition to this Declaration of Domestic Partnership, you must either provide proof of domestic partner registration in a state or locality that allows registration of domestic partner relationships OR (2) two items (dated at least 6 months prior to the Affidavit):

- ❑ **Joint Mortgage Lease or Deed**, or
- ❑ **Designation of the Domestic Partner as Durable Power of Attorney**,

- AND -

- ❑ **Joint bank account**, joint credit cards, or other evidence of joint financial responsibility, or
- ❑ **Designation of the Domestic Partner as primary beneficiary for life insurance**, retirement benefits or a legal will or trust

IV. Termination of Domestic Partner Status

I acknowledge and agree that it is my responsibility to notify the Company within 31 days if my Domestic Partnership status changes by contacting Team Member Service Center. I understand that I may not file another Declaration for Domestic Partnership for 6 months from the date of notification.

I understand that the company and its affiliates reserve the right to request documented proof of the above at any time. I also understand that if I do not provide documented proof when requested, or, if any of the information provided on this form is not true and correct, it will be considered a violation of Rules of Conduct and may result in termination of employment.

_____ _____

Your Name (Please Print) *Employee Number*

_____

Partner's Name (Please Print)

_____ _____

Employee Signature *Today's Date (MM/DD/YYYY)*

- **Secure Online Upload:** Visit the Benefits Service Center via my.aa.com and select the tile for "Dependent Verification Health & Travel" under the "Highlights for You" section (preferred) **or**
- **Secure Fax:** 1-877-965-9555 **or**
- **Mail:** Dependent Verification Center, P.O. Box 1401, Lincolnshire, IL 60069-1401