Certification of Domestic Partner Status for Exemption from California State Income Tax Withholding (Domestic Partner is not Employee's Dependent for Federal Income Tax Purposes)

If you and your enrolled domestic partner meet certain requirements under California law, no California state income taxes will be withheld from your pay on the cost of group health plan coverage for your enrolled domestic partner. Complete and return this form to certify to the Company that you and your enrolled domestic partner meet such requirements. If you do not complete and return this form, or if it turns out that you and your domestic partner do not actually meet the California requirements, California state income taxes will be withheld from your pay on the cost of the group health plan coverage for your enrolled domestic partner, unless you have separately certified that your domestic partner is your dependent for federal income tax purposes.

Employee Certification (to be completed by Employee): *PLEASE PRINT*

Employee Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Social Security Number	Employee Number

I, _____, certify (my "Certification") the following as true facts with regard to _____, ***who is my registered domestic partner in the State of California*** and who is the person I have enrolled in coverage under the Company's group health plan:

1. We both share a common residence.
2. Neither my domestic partner nor I are married to someone else or are a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
3. My domestic partner and I are not related by blood in a way that would prevent us from being married to each other in this State.
4. My domestic partner and I are at least 18 years of age.
5. My domestic partner and I are capable of consenting to the domestic partnership.

IMPORTANT: If any of items 1 through 6 above do not apply to your domestic partnership, no exemption from California state income tax is possible.

As part of my Certification, ***I also certify*** that my domestic partner and I have registered our domestic partner relationship with the State of California on _____ (***specify month, day and year***).

I certify that the information I have provided above is true, complete and correct. **I understand, agree and acknowledge that I must properly notify the Benefits Service Center within 31 days if there is a change in my domestic partnership or the tax dependent status of my domestic partner**. Any change in the tax dependent status of my domestic partner may directly impact the calculation of my taxable income.

I also understand, agree and acknowledge that my employer has a legitimate need to know the California tax status of my domestic partner relationship and that my employer may at any time and for any reason request that I provide such evidence as it may require to confirm any part of my Certification and that if such evidence is not sufficient to confirm any part of my Certification (as determined by my employer in its sole discretion) my employer may take action to commence withholding of California state income taxes from my pay on the cost of group health plan coverage for the person enrolled as my domestic partner.

In addition, I understand, agree and acknowledge that knowingly providing false or misleading tax information for the purposes of defrauding my employer can result in loss of benefits and/or loss of my job.

Employee Signature	Date Signed

This form and the Domestic Partner Certification should be submitted to the MPC Benefits Service Center| Phone: 1-888-421-2199, Option 1, then Option 3 |Email: benefits@marathonpetroleum.com | Web: www.myMPCbenefits.com

For additional information, review the Domestic Partner FAQs or visit www.myMPCbenefits.com.