Veeva Systems, Inc. Welfare Benefits Plan
Affidavit of Domestic Partnership

I. Information:

Employee Information:

Name	Employer
	Health Plan Participant No.
Address	

Domestic Partner Information:

Name	Employer
Address	

II. Requirements:

We certify that we are domestic partners for purposes of coverage under the Veeva Systems, Inc. Welfare Benefits Plan (the "Plan") and met the criteria set forth below. We understand that any misrepresentation with respect to whether we meet the plan's terms of eligibility constitutes insurance fraud and the plan will seek to recover any benefits paid on behalf of an ineligible individual and enforce disciplinary action up to and including termination.

By selecting this box ☐we certify that we satisfy the criteria for a domestic partnership under applicable state law; or

By selecting this box ☐we certify the following is true:

- We are 18 years of age or older and unmarried;
- We are not related by blood in any manner that would prohibit legal marriage;
- We have assumed mutual obligations for the welfare and support of each other;
- We have been sharing a common residence and living together as a couple in the same household for a minimum of 6 months;
- and
- We are each other's sole domestic partner.

III. Declaration:

We have provided the information in this Affidavit for use by Veeva Systems, Inc. for the sole purpose of determining eligibility for domestic partner benefits under the Plan. We are aware that a change in domestic partnership is relevant to the Plan's provision of benefits and must be reported immediately. We

agree to notify the Veeva Employee Success Department **NA_BENEFITS@VEEVA.COM** in writing within 30 days if there is any change in our status as domestic partners, including any of the information attested to in this Affidavit which would make us no longer eligible for employee or domestic partner coverage.

We acknowledge that in the event that we no longer meet one or more of the criteria set forth above, we will no longer be considered domestic partners and the Domestic Partner, and any dependents of the Domestic Partner, will no longer be eligible for coverage under the Veeva benefits programs.

We attest that the above information is true and accurate. Because any misrepresentation as to eligibility constitutes insurance fraud, we understand and agree that the Plan or insurer can recover any amounts paid on behalf of ineligible individuals. We understand and agree that Veeva Systems, Inc., the Plan or an insurer may rescind our health care coverage if Veeva Systems, Inc., the Plan or an insurer concludes that any misrepresentations in this Affidavit constituted fraud or were an intentional misrepresentation of material fact.

Employee **Domestic Partner**

_____ _____

Signature Signature

Printed Name: _____ Printed Name: _____

Date: _____ Date: _____

[State] or [Commonwealth] of _____ [state]

County of _____

On this _____ [day] of _____ [month], 20___, before me, the undersigned notary public, _____ [Employee] and _____ [Domestic Partner] personally appeared, proved to me through satisfactory evidence of identification, which were _____ [type of identification], to be the individuals who signed the preceding or attached document in my presence, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of their knowledge and belief.

[Seal]

_____

[Notary Public Signature]