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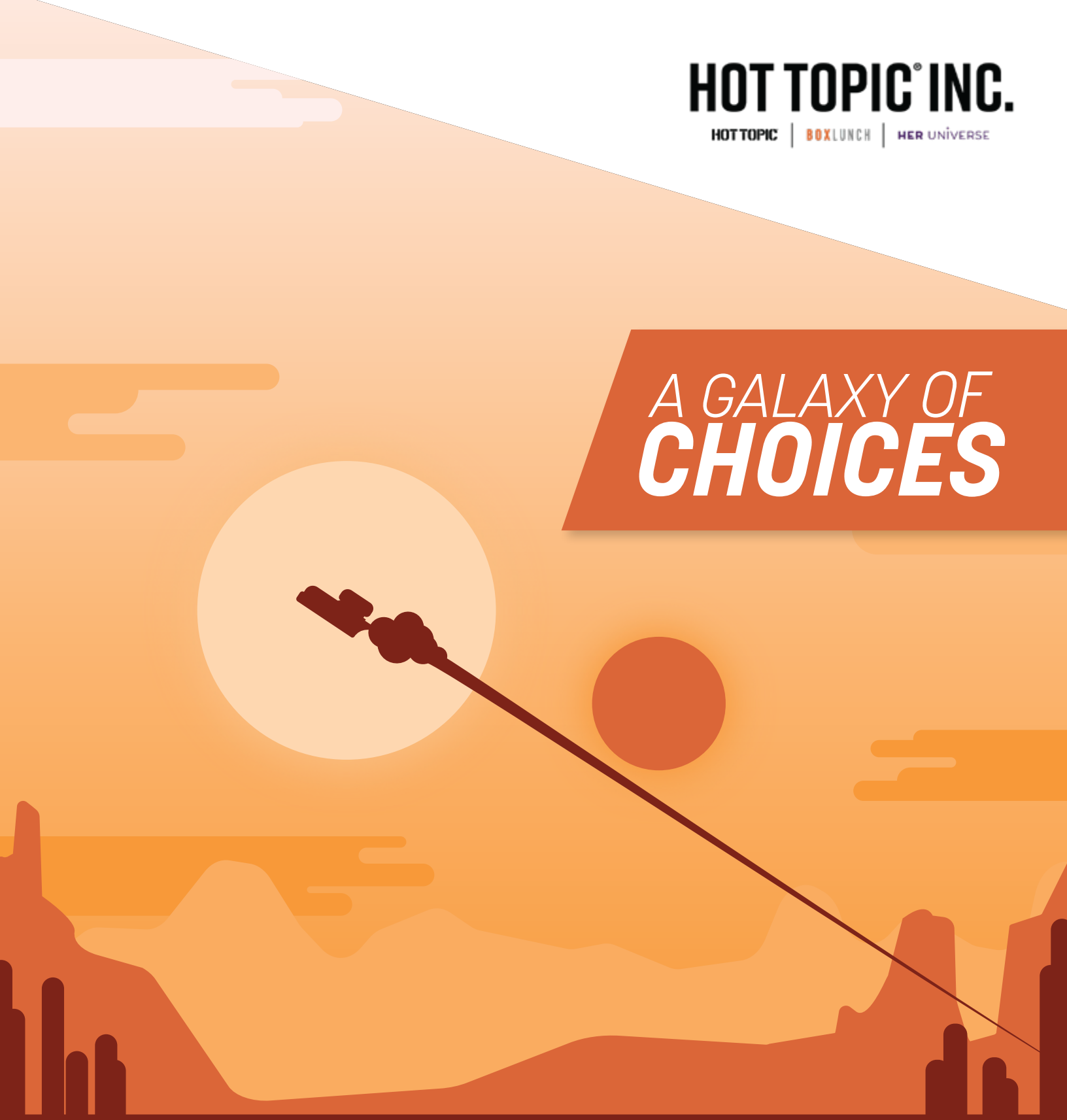

2026 DOMESTIC PARTNER ENROLLMENT GUIDE

FREQUENTLY ASKED QUESTIONS AND ANSWERS

Q. What is a Domestic Partner?

A. A relationship between two persons of the same sex or opposite sex who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. To be officially "registered" as domestic partners, certain criteria must be met, such as:

- Both persons having a common residence
- Both share responsibility of one another's financial obligation
- Neither person can be married or a member of another domestic partnership, etc.

Hot Topic allows Domestic Partners who have completed a Domestic Partner Affidavit to be eligible for medical, dental, and vision plans.

Q. What is imputed income, and how does it impact me?

A. In accordance with Internal Revenue Service (IRS) guidelines, Hot Topic's cost of providing benefits for domestic partners who do not meet the IRC Section 152 definition of qualified dependents is considered imputed income and therefore, is subject to taxes. You will be required to pay for the cost of your domestic partner's coverage on an after-tax basis; in addition, imputed income will be added to your W-2 wages when your domestic partner is not your tax dependent.

Q. What are the steps for adding a domestic partner to my coverage?

A. Here are the steps for adding a domestic partner to your coverage:

1. **Domestic Partnership Declaration**

   A new domestic partnership is considered a life event. A life event allows you to add eligible dependents to your current benefit plans or add benefit plans you did not already have. A domestic partner declaration is required and is proof of your life event. This document can be found in this guide attached on page 4. Your notarized domestic partner declaration and benefit enrollment form must be completed and submitted within 30 days of when the domestic partner declaration is notarized.

2. **Review Your New Premiums**

   Your new benefit premiums when adding a domestic partner can be viewed on page 3 of this guide. Here is a guide on plan coverage rates:

   EE + DP: This premium reflects coverage for Yourself + Your Domestic Partner

   EE + DP + EE's Children: This premium reflects coverage for Yourself + Your Domestic Partner + Your child(ren)

   EE + DP + DP's Children: This premium reflects coverage for Yourself + Your Domestic Partner + Domestic Partner's child(ren)

3. **Complete Domestic Partner Enrollment**

   Lastly, to complete this life event – new domestic partnership enrollment – please do so by completing pages 5-9, including a notarized declaration, the manual benefits enrollment form and Life Insurance beneficiary form, if applicable. Once you complete the forms, please send to benefits@hotopic.com for review and approval.

DOMESTIC PARTNER COST OF COVERAGE

In accordance with the IRS, Hot Topic's cost of providing benefits for domestic partners (DP) who do not meet the IRC Section 152 definition of qualified dependents is considered imputed income and is, therefore, subject to taxes. You will be required to pay for the cost of your DP's coverage on an after-tax basis; in addition, "imputed income" will be added to your W-2 wages when your DP is not your tax dependent. Contact the Hot Topic Benefits Department for more information.

Medical Rates For Your Domestic Partner (DP)

HOURLY (Non-Exempt)	After-Tax Deduction (per paycheck)				Amount Taxable as Income (per paycheck)			
Plan	"UHC Basic EPO*"	UHC EPO*	"UHC PPO**"	Kaiser HMO	"UHC Basic EPO*"	UHC EPO*	"UHC PPO**"	Kaiser HMO
EE + DP	$62.63	$100.09	$147.48	$180.95	$204.06	$230.80	$262.36	$215.88
EE + DP + EE's Child(ren)	$81.62	$120.96	$135.70	$190.53	$145.40	$160.72	$216.02	$147.09
EE + DP + DP's Child(ren)	$136.44	$206.83	$254.49	$343.50	$308.87	$345.68	$433.64	$319.87

"SALARY (Exempt) Up to $149.9k"	After-Tax Deduction (per paycheck)				Amount Taxable as Income (per paycheck)			
Plan	"UHC Basic EPO*"	UHC EPO*	"UHC PPO**"	Kaiser HMO	"UHC Basic EPO*"	UHC EPO*	"UHC PPO**"	Kaiser HMO
EE + DP	$64.78	$102.91	$150.85	$183.87	$201.91	$227.98	$258.99	$212.96
EE + DP + EE's Child(ren)	$80.41	$122.84	$136.04	$192.45	$146.61	$158.84	$215.68	$145.17
EE + DP + DP's Child(ren)	$137.99	$211.06	$258.60	$347.85	$307.32	$341.45	$429.53	$315.52

*CA – Select Network; Non-CA Choice Network

**CA – Select Plus Network; Non-CA – Choice Plus Network Note: Employees with an annual salary exceeding

$149,000 will have an additional amount added to their medical deduction.

Contact benefits@hottopic.com for those amounts.

DP DOCUMENTATION REQUIREMENT
To add your Domestic Partner, you must complete the DP Affidavit. Please scan the QR code (or click here), complete and return the Declaration of Domestic Partnership form can be returned to benefits@hottopic.com

Dental Rates For Your Domestic Partner (DP)

HOURLY & SALARY	After-Tax Deduction (per paycheck)			Amount Taxable as Income (per paycheck)		
Plan	DHMO	DPPO	PREMIUM DPPO	DHMO	DPPO	PREMIUM DPPO
EE + DP	$7.42	$11.06	$12.78	$0.42	$2.42	$2.43
EE + DP + DP's Child(ren)	$14.60	$24.37	$28.31	$0.26	$5.28	$5.29

Vision Rates For Your Domestic Partner (DP)

HOURLY & SALARY	After-Tax Deduction (per paycheck)			Amount Taxable as Income (per paycheck)		
Plan	CORE	BUY-UP	PREMIUM	CORE	BUY-UP	PREMIUM
EE + DP*	$0.30	$1.15	$1.53	$0.00	$0.00	$0.01
EE + DP + DP's Child(ren)*	$0.90	$4.56	$6.08	$0.00	$0.00	$0.01

You may only enroll your DP and/or DP's child(ren) in the vision core plan if they are enrolled in a Hot Topic medical plan.

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DECLARATION OF DOMESTIC PARTNERSHIP

I, _____ , [employee name] submit this Declaration of Domestic Partnership to establish

_____[partner name] as my domestic partner (as defined below) in order to obtain benefits that Hot Topic Inc. may extend to employees' eligible domestic partners and/or their children.

1. I declare that my partner and I are domestic partners as defined in at least one of the categories below:
   A. My partner and I are registered domestic partners under California law. We have jointly executed and filed a Declaration of Domestic Partnership with the California Secretary of State.
   B. My partner and I have a legal union, other than marriage, established in another state that is considered "substantially equivalent" to a registered domestic partnership in California.
   C. My partner is my "sole spousal equivalent". My partner and I meet Hot Topic Inc.'s definition of Domestic Partner as follows:
      1. We have a common residence.
      2. Neither of us is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
      3. We are not related by blood in a way that would prevent us from being married to each other.
      4. We are at least 18 years of age and capable of consenting to the domestic partnership.
      5. We have a committed relationship and our partnership is intended to be permanent.
      6. We are responsible for each other's common welfare.
2. I will provide to Hot Topic Inc. or designated representative any requested documents to verify my domestic partner's and his or her children's eligibility for Hot Topic Inc.'s benefits.
3. I agree to submit to Hot Topic Inc. a completed Hot Topic Declaration of Termination of Domestic Partnership within 30 days after the partnership ends, if applicable.
4. I understand I may be responsible for payment of taxes as a result of Hot Topic Inc. providing benefits to my domestic partner and his or her children.
5. I understand that providing false, misleading or untimely information or statements to Hot Topic Inc. related to my or my partner's benefits (or his or her children's benefits) may result in any or all of the following actions by Hot Topic Inc.: a requirement that I reimburse Hot Topic for all expenses, termination of my employment, and other legal action against me.

I declare under penalty of perjury under the laws of the state in which I reside that the foregoing is true and correct.

_____ Signature – Employee

_____ (Area Code) Telephone Number

_____ Employee ID Number

_____ Address

_____ Print Name

_____ City, State, Zip Code

Notarization is Required

State/Commonwealth of _____

County of _____

On _____, before me, _____, Notary Public, personally appeared _____personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person executed the instrument

_____ Signature of Notary Public

(PLACE NOTARY SEAL HERE)

RETURN COMPLETED FORM TO:

Hot Topic Inc
Benefits Department 18305
E. San Jose Ave City of Industry, CA 91748
HTBenefits@hottopic.com

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Benefit Enrollment Form 2026

Indicate Reason for Enrollment ☐ New Hire ☐ Promotion ☐ Life Event

Name (First, Last) _____ Employee# _____ Email Address _____

MEDICAL- Kaiser **Please choose either Kaiser CA or United Healthcare for medical coverage.*

☐ HMO

MEDICAL- United Healthcare **If Basic EPO, EPO & PPO are unavailable, the employee & dependents will be enrolled in the Indemnity Plan.*

☐ Basic EPO ☐ EPO ☐ PPO/Indemnity ☐ Waive Medical/Other Insurance

☐ Waive Medical/No other Insurance

DENTAL

☐ DHMO ☐ DPPO ☐ Premium DPPO ☐ Waive Dental Coverage

VISION- VSP *If waiving medical, the Core Plan is unavailable; but you may enroll in the Buy-Up Plan.

☐ Vision Core ☐ Vision Buy-Up ☐ Vision Premium ☐ Waive Vision

FLEXIBLE SPENDING ACCOUNT (FSA)

☐ Health Flexible Spending $
($100 minimum to a maximum of 3,300 per year)

☐ Dependent Flexible Spending $
($100 minimum to a maximum of $7,500 per year)

Your FSA election will be a bi-weekly check deduction. The amount deducted will be calculated based on the amount elected divided among the pay periods that remain in the plan year. For more information email benefits@hottopic.com

☐ Waive Flexible Spending

EMPLOYEE SUPPLEMENTAL LIFE INSURANCE *Evidence of Insurability may be required based on your election.

☐ Employee Supplemental Life
(Increments of $10,000 / Maximum $500,000) $_____ ☐ Waive EE Supp Life

DEPENDENT SUPPLEMENTAL LIFE INSURANCE

*You may enroll your Spouse/DP/Child only if you have elected Supp Life for yourself. Evidence of Insurability may be required based on your election.

☐ Spouse/DP Supplemental Life
(Increments of $5,000 / Maximum $250,000) $_____ ☐ Waive Spouse/DP Supp Life

☐ Child(ren) Supplemental Life
(Increments of $2,000 / Maximum $10,000) $_____ ☐ Waive Child(ren) Supp Life

LONG TERM DISABILITY BUY-UP - (Full-Time Associates Only) Long Term Disability Buy-Up ☐ Waive Long Term Disability Buy-Up

DEPENDENTS - Children up to age 26 can be covered on all plans.
Mark all plans for each dependent. Proof of relationship is required for each dependent.

Spouse/DP Name _____ SS# _____ Date of Birth _____ Gender _____ ☐ Spouse ☐ Domestic Partne

☐ Medical ☐ Dental ☐ Vision ☐ Remove Dependent

Dependent Name _____ SS# _____ Date of Birth _____ Gender _____ ☐ Child ☐ Other

☐ Medical ☐ Dental ☐ Vision ☐ Remove Dependent

Dependent Name _____ SS# _____ Date of Birth _____ Gender _____ ☐ Child ☐ Other

☐ Medical ☐ Dental ☐ Vision ☐ Remove Dependent

Dependent Name _____ SS# _____ Date of Birth _____ Gender _____ ☐ Child ☐ Other

☐ Medical ☐ Dental ☐ Vision ☐ Remove Dependent

LEGAL STUFF

GENERAL ACKNOWLEDGEMENT: I wish to enroll in, or decline, voluntary benefits as indicated on this election form. I understand that per IRS Section 125 rules, my portion of the premiums for medical, dental, vision & FSA coverage will be taken on a before-tax basis, with the exception of coverage for a Domestic Partner. I understand that if I would like my portion of medical, dental or vision premiums taken on an after-tax basis, I must complete an After-Tax Election Form (available from the Benefits Department). I further understand that deductions for Domestic Partner coverage will be taken on an after-tax basis and the portion paid by The Company will be added to my gross earnings for tax purposes. I authorize the company to take necessary before-tax and/or after-tax payroll deductions for those benefits I have chosen. In addition, should any of my insurance deductions not be taken due to my absence from work, I understand that I am required to make payments for those missed deductions. I further understand that the choices I make on this form (whether electing or declining), will remain in effect and may not be changed until the next Annual Open Enrollment period. My elections may only be changed if I experience a Life Changing Event (as determined by the IRS), such as marriage, death, divorce, birth or adoption of a child, or loss of other coverage.
Should one of these events occur, I must notify and provide required documentation to the Benefits Department within 30 days of the Life Changing Event in order to be eligible to make any coverage changes. I certify that the information on this form is true, complete and accurate to the best of my knowledge.

Employee Signature _____ Date _____

KAISER PERMANENTE®

Kaiser Foundation Health Plan Arbitration Agreement* California

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

By signing the below and enrolling in a Kaiser health plan, I understand that this action will serve as my electronic signature of agreement to the conditions provided in the Kaiser Foundation Health Plan Arbitration Agreement (above) and that by law this electronic signature will have the same effect as a signature on a paper form.

Note: If you do not wish to accept the arbitration agreement above you must chose another Health Plan selection. Do Not Sign.

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of- Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

Employee Signature _____ Date _____

Standard Insurance Company

Beneficiary Designation/Change

This designation will apply to the following Standard Insurance Company coverage(s) if available to you through your Employer: Life Insurance, Life with Accidental Death & Dismemberment (AD&D) Insurance, AD&D Insurance and, unless specified otherwise on a separate signed sheet of paper, Supplemental Life Insurance.

Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to your Employer during your lifetime. Return the completed form to your Human Resources Department.

MEMBER/EMPLOYEE INFORMATION

Your Name (Last, First, Middle) _____ Date of Birth _____

Your Address _____

City _____ State _____ Zip _____

Group Name Hot Topic Group No. 171859

BASIC LIFE/AD&D BENEFICIARY DESIGNATION/CHANGE

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary-John Q. Doe, 60%;Jane Q. Doe, 40%."

Primary- Full Name _____ Address _____ Birth Date _____ Phone No. _____

Soc. Sec. No. (*if known)* _____ Relationship _____ % of Benefit Total must equal JOO% 0.00%

Primary- Full Name _____ Address _____ Birth Date _____ Phone No. _____

Soc. Sec. No. (*if known)* _____ Relationship _____ % of Benefit Total must equal JOO% 0.00%

Signature of Member/Employee _____ Date _____

Additional Life Beneficiary Designation/Change

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary- John Q. Doe, 60%;Jane Q. Doe, 40%."

Primary- Full Name	Address	Birth Date	Phone No.
Soc. Sec. No. (*if known)*	Relationship	% of Benefit Total must equal JOO%	
		0.00%	
Primary- Full Name	Address	Birth Date	Phone No.
Soc. Sec. No. (*if known)*	Relationship	% of Benefit Total must equal JOO%	
		0.00%	

Signature of Member/Employee _____ Date _____


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