

HOT TOPIC® INC.

HOT TOPIC | BOX LUNCH | HER UNIVERSE

A GALAXY OF
CHOICES

20 DOMESTIC PARTNER
26 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) Plan	After-Tax Deduction (per paycheck)				Amount Taxable as Income (per paycheck)			
	"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" Plan	After-Tax Deduction (per paycheck)				Amount Taxable as Income (per paycheck)			
	"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 Plan	After-Tax Deduction (per paycheck)			Amount Taxable as Income (per paycheck)		
	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 Plan	After-Tax Deduction (per paycheck)			Amount Taxable as Income (per paycheck)		
	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.

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) 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

Dependent Flexible Spending \$ _____
 (\$100 minimum to a maximum of \$7,500 per year) 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 _____	<input type="checkbox"/> Spouse
				<input type="checkbox"/> Domestic Partne
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Remove Dependent				
Dependent Name _____	SS# _____	Date of Birth _____	Gender _____	<input type="checkbox"/> Child
				<input type="checkbox"/> Other
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Remove Dependent				
Dependent Name _____	SS# _____	Date of Birth _____	Gender _____	<input type="checkbox"/> Child
				<input type="checkbox"/> Other
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Remove Dependent				
Dependent Name _____	SS# _____	Date of Birth _____	Gender _____	<input type="checkbox"/> Child
				<input type="checkbox"/> Other
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> 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 _____

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. <i>(if known)</i>	Relationship	% of Benefit Total must equal JOO%	
		0.00%	
Primary- Full Name	Address	Birth Date	Phone No.
Soc. Sec. No. <i>(if known)</i>	Relationship	% of Benefit Total must equal JOO%	
		0.00%	
SI 11210	Human Resources Department - Retainfor your records.		171859 (10/23)

Signature of Member/Employee _____ Date _____

ACKNOWLEDGEMENT OF DOMESTIC PARTNERSHIP AGREEMENT

This Acknowledgement of Domestic partnership agreement is being executed by

_____, an employee of Hot Topic Inc (HTI)

(hereinafter “the Employee”), and _____, the employee’s Domestic Partner (hereinafter “the Domestic Partner”), which individuals shall collectively be referred to in this Acknowledgement at “the Parties.”

WHEREAS, the Employee is an employee of HTI;

WHEREAS, HTI has agreed to extend to HTI employees benefits for employees’ domestic partners when the insurance carrier or benefit provider permits benefits to be extended to domestic partners, including tuition waiver benefits;

WHEREAS, it is essential that HTI have the basis for verifying the right of the Employee to have benefits extended to his/her Domestic Partner;

WHEREAS, the Parties have advised HTI that they have entered into a Domestic Partnership Agreement providing for the joint responsibility for each others welfare, financial obligations, and basic living expenses;

WHEREAS, the parties are willing to provide HTI with this Acknowledgement of their Domestic Partnership Agreement in order to confirm eligibility to participate in the benefits as provided.

ACKNOWLEDGEMENT BY THE PARTIES

The Parties affirmatively acknowledge that the following statements below are true and accurate and are a part of the Domestic Partnership Agreement, which they have entered into:

1. Each Party is 18 years of age or older and have the capacity to enter into a contract; and
2. The Parties are involved in an exclusive, long-term and committed relationship; and
3. who have resided together in a common household continuously for at least six (6) consecutive months; and
4. The Parties intend to reside together indefinitely; and
5. The Parties are not related by blood to a degree of closeness which would prohibit legal marriage in the State in which the partners legally reside; and
6. The Parties have agreed to be jointly responsible for each other’s welfare, financial obligations, and basic living expenses, including food, shelter, and health care expenses; and
7. Neither of the Parties are married, are currently involved in any other domestic partnership, and have been involved in any other domestic partnership or marriage for the last twelve (12) months, unless that partnership or marriage ended because of death.

The Parties, having first read this Acknowledgement of Domestic Partnership Agreement, agree to the terms set out above and have affixed below their signatures to this Acknowledgement.

SIGNED IN THE PRESENCE OF:

Employee's Signature

Domestic Partner's Signature

Before me on this _____ day of _____, 20 _____ appeared _____, ("the Employee").

STATE OF _____)
_____)
_____)
NOTARY PUBLIC
My Commission Expires: _____
SS:

Before me on this _____ day of _____, 20 _____ appeared _____, ("the Domestic Partner").

NOTARY PUBLIC
My Commission Expires: _____

AFFIDAVIT OF DOMESTIC PARTNERSHIP

Employee

_____	_____	_____	_____
Last Name	First	Middle Initial	National ID (SSN)

Domestic Partner

_____	_____	_____	_____
Last Name	First	Middle Initial	National ID (SSN)

Domestic Partners are defined as two individuals of the same or opposite sex:

- 1. who are both 18 years of age or older and have the capacity to enter into a contract; and**
- 2. who are involved in an exclusive, long-term and committed relationship; and**
- 3. who have resided together in a common household continuously for at least six (6) consecutive months; and**
- 4. who intend to reside together indefinitely; and**
- 5. who are not related by blood to a degree of closeness which would prohibit legal marriage in the State in which the partners legally reside; and**
- 6. who have agreed to be jointly responsible for each other's welfare, financial obligations, and basic living expenses, including food, shelter, and health care expenses; and**
- 7. who are not married, who are not currently involved in any other domestic partnership, and who have not been involved in any other domestic partnership or marriage for the last twelve (12) months, unless that partnership or marriage ended because of death.**

DOCUMENTATION OF DOMESTIC PARTNERSHIP

I am an employee of Hot Topic Inc., have attached to this affidavit the following as documentation of the domestic partnership:

(Please check the items submitted):

_____ An Acknowledgement of Domestic Partnership Agreement, which acknowledges that an agreement exists between myself and my domestic partner that creates personal and financial liability and responsibility for each other's welfare, financial obligations, and basic living expenses, including food, shelter, and health care expenses. This acknowledgement is to be in the form set out in Exhibit A to this Affidavit.

AND any two (2) of the following as verification of the domestic partnership's joint responsibility for each other's welfare, shared financial obligations and basic living expenses.

_____ Joint deed, joint mortgage agreement, or joint lease

_____ Designation of the domestic partner as primary beneficiary for a life insurance contract or retirement account

_____ Designation of domestic partner as primary beneficiary of will

- _____ Durable power of attorney for health care or financial management designating domestic partner as power of attorney
- _____ Joint ownership of a motor vehicle
- _____ Joint checking account
- _____ Joint credit account
- _____ Co-parenting or adoption agreement

CERTIFICATION OF DOMESTIC PARTNERSHIP

I, as an employee of HTI, hereby certify that the above-named person and I meet all the eligibility requirements as “Domestic Partners” as defined above.

I understand all of the following:

- 1) domestic partners are eligible for all benefits when the insurance carriers or benefit provider permits benefits to be extended to domestic partners;
- 2) non-employee domestic partners and dependent children of domestic partners are eligible to tuition waiver benefits, to the same extent and subject to the same rules and eligibility requirements as are applicable to employees.
- 3) under federal and state law, benefit coverage of the non-employee domestic partner and his/her children, including tuition waiver benefits, may result in taxable income to the employee and is subject to income tax withholding and applicable payroll taxes;
- 4) coverage for non-employee domestic partners may only be activated during open enrollment and is effective for one calendar year. Coverage may begin during the calendar year only if a qualifying change in family or job status occurs during that calendar year. Please see Benefits Overview and Enrollment Guide.
- 5) domestic partners are not eligible for continuing coverage under COBRA;
- 6) the employee must give written notice to Human Resources within thirty (30) days of any change of circumstances attested to in this Affidavit or of the termination of the domestic partnership, and file an amendment to the Affidavit or a termination of the Affidavit form;
- 7) another Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a statement or termination of the previous partnership has been filed with Human Resources, unless that domestic partnership ended because of death;
- 8) falsely certifying eligibility for domestic partner benefits or failing to inform HTI if the domestic partnership ceases to meet eligibility requirements in any respect will result in disciplinary action against the employee;
- 9) the employee will be liable for all expenditure for coverage and benefits, including tuition waiver benefits, that the employee obtained because of any misrepresentation or omission on this Affidavit, in certifying eligibility for benefits, or in failing to inform HTI that the domestic partnership ceases to meet eligibility requirements;
- 10) employees are permitted to use the information provided on this Affidavit to administer the benefits outlined above; and
- 11) the information contained in this Affidavit will be held confidential to the extent possible and will be subject to disclosure to third parties outside the Hot Topic Inc. only upon the employee’s written consent, pursuant to a court order or as otherwise required by law.

CERTIFICATION OF DEPENDENT CHILDREN

I certify that the children of my domestic partner names below meet the following requirements:

- 1) The children reside within the household of the domestic partnership; and
- 2) The children are unmarried and (a) are under the age of 19, or (b) are full-time students and under the age of 23, or (c) are of any age and are mentally or physically incapable of supporting themselves; and
- 3) The children are dependent upon me and/or my domestic partner for at least 50 percent of their support; and
- 4) I, or my domestic partner, have a court-appointment legal relationship with the children (i.e. adoption, guardianship, foster child) or my domestic partner is the biological parent of the child

Proof of dependency may be required.

Partner's Dependent Children

_____ Last Name	_____ First	_____ Middle Initial	_____ Birth Date	_____ National ID (SSN)
_____ Last Name	_____ First	_____ Middle Initial	_____ Birth Date	_____ National ID (SSN)
_____ Last Name	_____ First	_____ Middle Initial	_____ Birth Date	_____ National ID (SSN)

I affirm, under the penalty of perjury that the assertions in this Affidavit are true and accurate to the best of my knowledge.

Employee's Signature

Date

Before me on _____ day of _____, 20____ appeared
 this _____ of _____

_____, who was sworn and subscribed his/her name above.

 NOTARY PUBLIC



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