Alexander & Baldwin, Inc.
Affidavit of Domestic Partnership

I. DECLARATION

We, ____, and
(Print name of "Employee")
____ being duly sworn
(Print name of "Domestic Partner")

under oath, do certify and declare that we are domestic partners in accordance with the following and are eligible for the benefits programs provided by Alexander & Baldwin, Inc., and its divisions and subsidiaries ("A&B"):

II. DOMESTIC PARTNER CRITERIA

1. We are each other's sole Domestic Partner and reside together in the same residence and intend to remain so indefinitely and are responsible for our common welfare.
2. We agree to financially support each other during the time of our domestic partner relationship by being jointly responsible for each other's necessities, including without limitation, food, clothing, housing and medical care.
3. We are not legally married to or separated from anyone nor are we in another domestic partnership which has not been terminated or dissolved.
4. We are at least eighteen (18) years of age or older and are mentally competent to consent to this contract.
5. If applicable, we are California residents of opposite gender and one of us is over age 62 (a copy of the birth certificate is attached).
6. We are not related by blood closer than that which would bar marriage in our state of residence.
7. This relationship has been in existence for a period of at least twelve (12) consecutive months, and we have jointly shared the same residence for at least six (6) months.
8. We have executed a domestic partnership agreement and/or registered as domestic partners, or the equivalent, in a jurisdiction that authorizes such agreements and/or registries, **OR** our relationship meets at least three of the following four conditions (please check those that apply, A-D):

   ___ A. We have common or joint ownership of a residence (home, condominium, or mobile home).

   ___ B. We have at least two of the following (please check which two apply):

   ___ 1) Joint ownership of a motor vehicle
   ___ 2) Joint checking account
   ___ 3) Joint credit account
   ___ 4) Lease for a residence identifying both partners as tenants
   ___ 5) Durable power of attorney for health care or financial management

   ___ C. The Domestic Partner has been designated as the primary beneficiary for at least one of the following (please check which one applies):

___ 1) The Employee's life insurance contract
___ 2) The Employee's will
___ 3) The Employee's retirement savings plans

___ D. A "relationship contract" has been executed which obligates each of the parties to provide support for the other party and provides, in the event of the termination of the relationship, for a substantially equal division of any property acquired during the relationship.

NOTE: Documentation may be required to prove the existence of any of the above-mentioned items.

III. CERTIFICATION OF DOMESTIC PARTNER AS A DEPENDENT

Please consult a tax advisor before you certify that your domestic partner seeking coverage is a dependent as defined by the Internal Revenue Code. If your answer to the question below is YES, you are not taxed on imputed income for the dependent coverage premiums paid by A&B, and you are able to make contributions for your domestic partner's coverage on a pre-tax basis.

Please check one:

Yes, my domestic partner qualifies as my dependent for federal income tax purposes. I have executed the Domestic Partner Tax Dependency Certification Form which is attached.

I understand that on the basis of the above statements, A&B will consider the above person my dependent for all federal income and employment tax purposes.

I agree to reimburse A&B for any liability including, without limitation, taxes, penalties, or losses (including reasonable attorneys' fees) that A&B may incur arising out of its reliance on this affidavit if it is untrue in any respect, or if I fail to provide notice required by section IV.

No, my domestic partner does not qualify as my dependent for federal income tax purposes.

IV. CHANGE IN DOMESTIC PARTNERSHIP

1. I, the employee, agree to notify my human resources representative, in writing (see #2 below), within thirty (30) days if there is any change in our status as domestic partners as attested in the Affidavit which would make the Domestic Partner and/or any of his/her dependent children ineligible for the benefits provided by A&B (for example, due to death of a partner, a change in joint residence, termination of the relationship).

2. I will obtain the Affidavit of Termination of Domestic Partnership form from my human resources representative, which I will complete to affirm that the partnership is terminated. Domestic Partner coverage will be terminated as of the end of the month in which the termination affidavit is received by the human resources

representative. No notice of the termination will be sent to the domestic partner, or the domestic partner's dependents, if any.

3. I understand after termination of the Domestic Partnership, another Affidavit of Domestic Partnership cannot be filed with the Human Resources Department until twelve (12) months have elapsed after which I may enroll my Domestic Partner in my health, dental, and vision insurance and employee assistance program subject to A&B's eligibility and enrollment rules.

V. ACKNOWLEDGEMENTS

1. We understand that we must meet the eligibility requirements of the particular benefit plan(s) we are requesting. We also understand that A&B will not provide COBRA rights to a domestic partner or his/her children if the partnership is dissolved, or if the employee terminates employment, or if the domestic partner's dependents have an event that makes them ineligible for the employee's plan.

2. We understand that if both the "Employee" and "Domestic Partner" are A&B employees eligible for health, dental, and vision insurance, then selection of family coverage under the domestic partner provision effectively waives any right of either party to single coverage benefits or contributions during the time the partnership is in effect.

3. We understand that any person, employer, or company who suffers any loss because of false statements contained in this "Affidavit of Domestic Partnership" may bring civil action against either or both of us to recover their losses, including reasonable attorney's fees and costs.

4. We provide the information in this affidavit to be used by A&B's Human Resources Department for the sole purpose of determining our eligibility for Domestic Partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our expressed written authorization or pursuant to a court order.

5. We understand that this affidavit may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing the Affidavit, we should seek competent legal, tax and accounting advice concerning such matters.

VI. DEPENDENT CHILD/CHILDREN OF A DOMESTIC PARTNER

I, the above named Domestic Partner, certify that the following are my eligible dependent children:

Name	Date of Birth	Social Security Number

An eligible dependent child can be your natural child; a legally adopted child; a child placed with you for adoption; a child for whom you have legal guardianship, a stepchild; foster child; or a child for whom you have a legal obligation to provide medical insurance. Dependent children must meet the following requirements:

1. The child is not married, and either under 19 years of age or a full-time student under 24 years of age; or
2. The child is totally and permanently disabled, either physically or mentally. If this is the case, the disability must have existed before the child was age 19, and the dependent must have had continuous health care coverage with the carrier of choice since, on, or before that birthday.

VII. AFFIRMATION

We affirm, under penalty of perjury, that the statements in this affidavit are true to the best of our knowledge. We understand that this form is not an application for insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under the A&B's employee benefits program.

______________________________	______________________________
(Print Name of Employee)	(Print Name of Domestic Partner)
______________________________	______________________________
(Signature of Employee)	(Signature of Domestic Partner)
______________________________	______________________________
(Employee's Date of Birth)	(Domestic Partner's Date of Birth)
______________________________	______________________________
(Employee's Social Security No.)	(Domestic Partner's Social Security No.)
______________________________	______________________________
(Date)	(Date)