

AFFIDAVIT/AFFIRMATION OF DOMESTIC PARTNERSHIP

I. DECLARATION

I, _____, and I, _____
(Employee' Full Name) (Partner's Full Name)

affirm, individually, that we are engaged in a domestic partner relationship in accordance with the following criteria and are eligible for healthcare benefits as domestic partners under the _____.

II. STATUS

1. We have maintained a legal residence together for the past 12 months and intend to remain so indefinitely.
2. We are of the same sex, and neither of us is married to or legally separated from anyone else.
3. We are each other's sole domestic partner, live in a spouse-like relationship, and intend to remain so indefinitely.
4. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state or jurisdiction in which we legally reside, were we of the opposite sex.
5. We are not in a state or jurisdiction which permits same-sex marriage, and
6. We are jointly responsible for each other's basic living expenses and are financially interdependent.
7. We are at least eighteen (18) years of age and mentally competent to consent to contract.
8. We are not in this relationship solely for the purpose of obtaining benefits coverage.

III. CHANGE IN DOMESTIC PARTNERSHIP

1. We agree to notify the _____ if there is any change in our status as domestic partners as attested to in this Affidavit which would affect our eligibility for healthcare benefits (for example, if we cease to reside together or if we are no longer each other's domestic partner). We agree to notify the _____ within thirty (30) days of such change by filing a Statement of Dissolution of Domestic Partnership ("Statement of Dissolution"), affirming that the domestic partnership status has ended as of its date of execution.
2. After such dissolution, I, _____ (employee or member), understand that a subsequent Affidavit of Domestic Partnership may not be filed until any subsequent domestic partner relationship meets the criteria specified in Section II, *Status* of this Affidavit. (The 12 month relationship period specified under *Status* may be waived if the subsequent Affidavit is filed for the same domestic partner who is signatory to this Affidavit.)

We understand that failure to notify the _____ when a domestic partnership has been dissolved, or the use of false or misleading documents to obtain coverage when, in fact, we do not reside together or are not financially interdependent, may have serious legal consequences. In the event that medical or dental expenses have been paid by the _____ or one of its healthcare vendors as a result of any false representations, we understand the _____ or its healthcare vendor will seek reimbursement of those expenses and may elect to pursue the matter through civil legal action.

IV. ACKNOWLEDGMENTS

1. We understand that failure to notify the _____ when a domestic partnership has been dissolved and/or the use of false or misleading documents to obtain coverage may have serious legal consequences to both parties. If medical or dental claims have been paid by the _____ or one of its healthcare vendors as a result of false representations, we understand that the _____ and/or its healthcare vendor will seek reimbursement of those expenses and reserves the right to pursue the matter through civil legal action.
2. We have provided the information in this Affidavit for use by the _____ for the sole purpose of determining our eligibility for domestic partnership benefits.
3. We understand that the value of domestic partnership benefits coverage may be taxable as income.
4. We understand that some courts have recognized non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing community property and that the filing of this affidavit may have

other legal consequences.

5. Even though the _____ attests that we are eligible for healthcare benefits as determined by its criteria for domestic partnerships, we understand that healthcare benefits may not be available in every medical market or from every healthcare vendor offered to the employee's group.
6. We understand that the domestic partner identified in this Affidavit and the partner's eligible dependents may continue existing healthcare benefits coordinated by the _____ for up to 12 months from the end of the quarter in which the employee dies, or terminates employment, or in which the domestic partnership is dissolved. We understand the extension must be requested and paid for as required by the _____ and that such an extension may not be available in all healthcare markets.
7. We understand that, since Medicare does not acknowledge domestic partnerships, all domestic partnership benefits coordinated by the _____ will cease when Medicare becomes primary for the retired employee.

We, the undersigned domestic partners, currently share the same physical residence and are financially interdependent. We submit the following copies of two items as proof evidencing our cohabitation and financial interdependence:

- _____ Joint bank account statements
- _____ Joint credit card statements
- _____ Loan agreement indicating joint obligation
- _____ Property Deed
- _____ Residential tenants lease
- _____ Common public utility or telephone bills

V. STATEMENT

We affirm, under penalty of perjury, that, to the best of our knowledge, the assertions in this Affidavit are true and correct.

Employee Signature

Social Security Number

Domestic Partner Signature

Social Security Number

Street Address

Date

City, State, Zip

Witnessed by: _____

Signature of Group Administrator

Date

State of: _____

County of: _____

On this _____ day of _____, _____, _____, _____ [name] and _____ [name] personally appeared before me and each acknowledged having signed the forgoing instrument as his/her free act and deed.

[Notarial Seal]

(Notary Public)