Lake County School District 7

Code: **GCBC/GDBC-AR**
Revised/Reviewed: 10/13/08; 3/28/11
Orig. Code(s): GCBC/GDBC-AR

Affidavit of Domestic Partnership

Section 1

I, _____ and _____ are domestic partners and we:
(Name) (Name of Domestic Partner)

1. Are each 18 years of age or older;

2. Share a close personal relationship and are responsible for each other's common welfare;

3. Are each other's sole domestic partner;

4. Are not legally married to anyone nor have had another domestic partner within the previous six months;

5. Are not related by blood closer than would bar marriage in the state of Oregon;

6. Have jointly shared the same regular and permanent residence for at least six months immediately preceding the date of this Affidavit with the intent to continue doing so indefinitely;

7. Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. If requested, we would be able to provide at least three of the following as verification of our joint responsibility (information should be dated to confirm eligibility at time of enrollment):

    a. Joint mortgage or lease;
    b. Designation of the domestic partner as primary beneficiary for a life insurance or a retirement contract;
    c. Designation of the domestic partner as primary beneficiary in the employee/covered member's will;
    d. Durable power of attorney for health care or financial management;
    e. Joint ownership of a motor vehicle, a joint checking account or a joint credit account;
    f. A relationship or cohabitation contract which obligates each of the parties to provide support for the other party.

8. Were mentally competent to consent to contract when our domestic partnership began.

Section 2

1. I understand that my domestic partner is eligible for enrollment only:

    a. After the first 31 days of eligibility upon receipt of this properly executed Affidavit and a completed health statement acceptable to OEBB.

2. I understand further that children of my domestic partner are eligible if they:

    a. Are unmarried;
    b. Are under age 21; and
    c. Reside in the household (with two exceptions, full-time student at an accredited school or court-ordered dependent coverage).

3. I understand that coverage for my domestic partner shall terminate upon a change in circumstance attested to in Section One of this Affidavit.

4. I agree to provide written notice to my payroll/personnel representative if there is any change of circumstances attested to in this Affidavit within 30 days of the change by filing a Statement of Termination of Domestic Partnership.

5. After such termination, I understand that an application to add a new domestic partner cannot be filed earlier than six months from the filing of a Statement of Termination of Domestic Partnership with my payroll/personnel representative.

Section 3

1. We understand that the information contained in the Affidavit will be held confidential and will be subject to disclosure only upon the express written authorization or as required by law.

2. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs because of a willful falsification of information contained in this Affidavit of Domestic Partnership.

3. We understand that under applicable federal and state income tax law, payments for health coverage of a domestic partner may not be eligible under Section 125 Plan (if available through that group) and further that coverage of the nonemployee domestic partner could result in additional taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes).

4. We understand that, in addition to the contract eligibility requirements of my group for domestic partner coverage, there are terms and conditions of coverage set forth in the group contract of each health care plan offered through my group to which we agree to be bound.

5. We understand willful falsification of information contained in this Affidavit may result in our termination from enrollment under the health care plan which we select.

6. We also certify under penalty of perjury under the laws of the state issuing the contract that the foregoing is true and accurate to the best of our knowledge.

Signature of Employee	Signature of Domestic Partner
Date	Date

Address: _____

_____

STATE OF OREGON)
)
) ss:
)
)
County of)

SUBSCRIBED AND SWORN to before me this _____ day of _____.

_____
Notary Public of Oregon

_____
My Commission Expires:

Statement of Termination of Domestic Partnership

I, _____, affirm that the Affidavit of Domestic partnership
(Name of Employee)
attested to and signed by me on _____ shall be and is terminated as of this date.
Date of Affidavit

Termination is due to:

☐ Termination of domestic partnership because of a change in one or more of the circumstances attested to in Section I of the Affidavit.

☐ Death of domestic partner.

I understand that I cannot file a Statement of Domestic Partnership to enroll a new domestic partner until six months following the receipt of this statement by my employer.

Signature of Employee: _____ Date: _____

Received by:

Employer Representative: _____ Date: _____

Taxable Value of Health Insurance Coverage for Domestic Partners

According to the Internal Revenue Service, health insurance coverage for domestic partners is a taxable benefit to the employee. District employees who enroll domestic partners in the health plans will have to pay income taxes on the fair market value of the health insurance coverage their domestic partners receive. The value of the domestic partner insurance coverage is considered earnings, is included in the employee's gross taxable income and is subject to state and federal income tax and FICA withholding. The taxable value of the domestic partner coverage will depend on which health plan the employee is enrolled in and the number of dependents enrolled. Each pay period the taxable value of the benefit will be reflected on the employee's paycheck stub (or notice of deposit). The district will simply add the value of the benefit to gross wages of the employee.

I have read this statement and received a copy of it.

Employee: _____ Date: _____