Rainier School District 13

Code: **GCBC/GDBC-AR**
Revised/Reviewed: 10/18/00

Affidavit of Domestic Partnership

Section 1

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

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. During the first 31 days of eligibility following date of my employment;
    b. After the first 31 days of eligibility upon receipt of this properly executed Affidavit and a completed health statement acceptable to the insurance carrier; or
    c. Based on your group's contract after the first 31 days of eligibility upon receipt of this properly executed Affidavit and at open enrollment.

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 and as an employee may result in discipline up to and including dismissal.

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 _____, 20 _____.

_____
Notary Public of Oregon
My Commission Expires: _____

Statement of Termination of Domestic Partnership

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

Termination is due to:

- ☐ Termination of domestic partnership because of a change in one or more of the circumstances attested to in Section 1 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: _____