

Affidavit of Domestic Partnership

Section 1

We, (Please Print) _____ and _____
(Name of Employee)

are and have been the other's partners in a domestic partnership. For the purpose of this affidavit, a domestic partnership is one consisting of two people in which members are of the same gender, 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 married to anyone nor have had another domestic partner enrolled in the health plan within the prior six months;
5. Are not related by blood closer than would bar marriage in the states of Washington or Oregon;
6. Are prohibited from marrying under the laws of Washington or Oregon for reasons other than those listed in number 4 or 5 above, or because of the age of either individual;
7. Share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
8. Were mentally competent to consent to contract when our domestic partnership began;
9. Are jointly financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and any other expenses of maintaining a household. (Note: 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.)

Section 2

1. I understand that my domestic partner is eligible for enrollment only during open enrollment or at the time of my hire; or upon an event qualifying the domestic partner as newly eligible, provided all carriers agree to the same.
2. I understand that children of my domestic partner are eligible if they meet the requirements for an eligible defined by the health plan.
3. I understand that domestic partner and his/her child(ren) shall terminate upon the death of my domestic partner or upon a change in circumstances attested to in Section One of this Affidavit.
4. I agree to provide written notice to my payroll/personnel representative if there is a material change in the circumstances attested to in Section One of the Affidavit or the death of my Domestic Partnership or other appropriate notice.
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. We agree that each of us is an agrees to be jointly and severally liable for such losses proven.
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.
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 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
Date of Affidavit
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 One 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: _____