

Affidavit of Domestic Partnership

Section 1 – Declaration of Domestic Partnership

We, _____, and _____ certify and declare that we are domestic
(Name of Employee) (Name of Domestic Partner)

partners in accordance with the following criteria and are eligible for certain insurance benefits under the employer's benefit program.

Section 2 – Domestic Partner Criteria

1. We are each other's sole domestic partner as set forth in Item 5 and intend to remain so indefinitely.
2. Neither of us is currently married or legally separated, or have been in a relationship with another domestic partner within the last twelve (12) months..
3. We are at least eighteen (18) years of age and mentally competent to consent to this affidavit.
4. We have continuously resided together in the same residence for at least six (6) months.
5. We share a committed and mutually dependent relationship with each other that is similar to that of a married couple, but we have either chosen not to marry or cannot legally marry.
6. We recognize that domestic partner benefits are not provided under all plans and understand that we must meet the eligibility requirements of particular benefits plans we are requesting.
7. We are not related by blood closer than would otherwise prohibit legal marriage in the state of residence.

Section 3 – 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 is **YES**, you are not taxed on imputed income for the dependent coverage premiums paid by the employer, and you are able to make contributions for the 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 understand that on the basis of the above statements, my employer will consider the above person my dependent for all federal income and employment tax purposes.
 - I agree to reimburse my employer for any and all liability including, without limitation, taxes, penalties or losses (including reasonable attorney's fees) that my employer may incur arising out of its reliance on this affidavit if it is untrue in any respect or if I fail to provide the notice as required by Section 4.
 - Listed below are my domestic partner's children:

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

Section 4 – Change in Domestic Partnership

1. I agree to notify the employer, as required by this Section 4, if there is any change in our status as domestic partners as attested in this affidavit, which would make the non-partner/employee domestic partner and/or any of his/her dependent children ineligible for my employer's partner/employee benefit program (for example, due to the death of a partner, a change in joint residency, termination of the relationship, etc.).
2. I will notify the employer within thirty (30) days of such change in our status as domestic partners and/or dependent. Coverage under the employer's benefits program will be terminated in compliance with the rules of the programs.

Section 5 – Acknowledgements

1. We understand that any person/employer/insurer/claims administrator who suffers any loss due to any false statement contained in this Affidavit may bring civil action against either or both of us to recover their losses, including reasonable attorney's fees.
2. We have provided the information in this Affidavit for use of the employer, for the sole purpose of determining our eligibility for domestic partner benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization, pursuant to a court order or if there is a compelling business need to have access to the information.
3. 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 this Affidavit, we should seek competent legal and accounting advice concerning such matters.
4. We understand willful falsification of information contained in this declaration will result in termination of coverage for my domestic partner and his/her children, if any.

We declare, under penalty of perjury, under the laws of the state of New York that the assertions in this Affidavit are true to the best of our knowledge. We understand that this form is not an application for health insurance coverage and that the purpose for this

form is to establish the eligibility of persons named herein for the coverage provided under the employer's partner/employee benefits program.

Name of Employee

Name of Domestic Partner

Signature of Employee *Date*

Signature of Domestic Partner *Date*

Employee's Date of Birth

Domestic Partner's Date of Birth

Social Security Number

Social Security Number

Street Address / City, State, Zip

Employer Name

Group Plan #

Sworn to me on this _____
day of _____, 20____

Sworn to me on this _____
day of _____, 20____

Notary Public

Notary Public