Domestic Partner Affidavit

Your Name: ____ Employer's Name: ____

We, ____ and ____,
(Print your name) (Print domestic partner's name)

certify that we are domestic partners in accordance with the following criteria and are eligible for benefits/coverage as domestic partners under the above employer's benefit plan.

- We have been residing together continuously for at least twelve (12) months prior to the date indicated below as each other's sole domestic partner.
- We intend to live together in accordance with our exclusive mutual-interpersonal commitment.
- We are not related by blood to a degree that would legally prohibit a marriage in the state in which we live.
- We are not married to, a party to a civil union with, or in a domestic partnership with any person other than the person with whom we are executing this Affidavit.
- We are legally and mentally competent to enter a contract in the state in which we reside.
- We are jointly responsible for our common welfare and financial obligations and intend to continue to do so.

We also attest to the following:

- We will notify the appropriate person within thirty (30) days of a status change that would terminate our domestic partnership. Should such a change occur, a Statement of Domestic Partner Termination form will need to be completed and given to the benefits administrator of the employer providing this coverage. A change in status would include, but not be limited to:
  - Our failure to meet any of the six (6) required criteria described above in this Affidavit
  - The death or residence change of one partner
- We understand that termination of coverage for any reason will be effective in accordance with the conditions in the group insurance policy.
- We understand that coverage will not be provided for a domestic partner if the state in which we live does not allow such coverage. We understand that it is our obligation to determine whether our state of residence allows such coverage.
- When coverage is terminated a subsequent Domestic Partner Affidavit cannot be filed for twelve (12) months. This time requirement may be waived if another Affidavit is filed for the same domestic partner within thirty-one (31) days following the filing date of the Statement of Domestic Partner Termination form.
- We affirm that the assertions in this Affidavit are true to the best of our knowledge.
- We understand that any person/employer/company who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us to recover their losses, including reasonable attorney fees.
- We understand that if we fail to provide updated information as required herein, our health coverage may be terminated retroactive to the date this affidavit was signed.

____ ___________________________
Employee Signature Date

____ ___________________________
Domestic Partner Signature Date

____ ___________________________
Notary Public Signature* Date

Retain a copy of this Affidavit with your important papers as it may be needed at time of claim.

*Or other person authorized to take an oath under the law of the state in which this Affidavit is executed.