Affidavit of Domestic Partnership

We, the undersigned, certify that we are domestic partners in accordance with one of the following:

- ☐ We satisfy the criteria for a domestic partnership under applicable state law; or
- ☐ We satisfy all of the following criteria:
  - We are 18 years of age or older and unmarried.
  - We are not related by blood in any manner that would prohibit legal marriage.
  - We have assumed mutual obligations for the welfare and support of each other.
  - We have been sharing a common residence and living together as a couple in the same household for a minimum of 6 months.
  - We are each other's sole domestic partner.
  - **We are able to provide verification of our joint responsibility**, if requested. *(Refer to Domestic Partner Benefits Policy – provide at least two forms of evidence)*

We acknowledge that in the event that we no longer meet one or more of the criteria set forth above, we will no longer be considered domestic partners and will immediately file an Affidavit of Termination of Domestic Partnership form with the HR department. The Domestic Partner, and any dependents of the Domestic Partner, will no longer be eligible for coverage under the benefits programs.

We declare, under penalty of perjury, that all of the information we have provided on this form is true and correct.

I, the Enrollee, understand that any false or misleading statements made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my domestic partner and his or her dependents and to disciplinary action up to and including termination of employment and possible charges of fraud.

Employee Information

Name	**Date of Birth**

Signature	**Date**

Domestic Partner Information

Name	**Date of Birth**

Signature	**Date**

Address of Residence Shared by Both Domestic Partners:

City	**State**	**Zip Code**