Affidavit of Domestic Partnership

1. Domestic Partners

This form is only required for domestic partnerships not documented in a state registry. If your domestic partnership is registered in a state registry, you are eligible to enroll on the medical plan without completion of this form.

A. I,______________________________________certify that I, and ______________________________________
Print Name of Employee Print Name of Domestic Partner

are domestic partners, and we:

1. currently share the same regular and permanent residence, and
2. have a close personal relationship, and
3. are jointly responsible for "basic living expenses" as defined below, and
4. are not married to anyone, and
5. are each eighteen (18) years of age or older, and
6. are not related by blood closer than would bar marriage in this state, and
7. were mentally competent to consent to contract when our domestic partnership began, and
8. are each other's sole domestic partner and are responsible for each other's common welfare.

B. "Basic living expenses" means the cost of basic food, shelter, and any other expenses of a domestic partner. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

2. Employee

A. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change in the circumstance attested to in this Affidavit.

B. I agree to notify my employer if there is any change in circumstances attested to in this Affidavit within thirty (30) days of the change.

C. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed within__________as determined by the Group, but in no case less than 90 days, after a request for termination of domestic partnership has been filed with the Business Office. (This provision does not apply to state-registered domestic partners.

3. Agreement

A. We understand that this information will be held confidential and will be subject to disclosure only to Benefit Solutions, Inc. for purposes of confirming our eligibility or upon our written authorization or as required by law.

B. We understand that this declaration of responsibility for our common welfare may have legal implications under state law.

C. We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, because of a false statement contained in this Affidavit of Domestic Partnership.

D. We also certify under penalty of perjury, under the laws of this state, that the foregoing is true and correct.

E. I, the undersigned Employee, understand that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance coverage.

____ ____
Signature of Employee Signature of Domestic Partner

__________/__________/__________ __________/__________/__________
Date Signed (MM/DD/YYYY) Date Signed (MM/DD/YYYY)