GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

AFFIDAVIT OF DOMESTIC PARTNERSHIP

EMPLOYER NAME: _____ GROUP NUMBER: _____

We, _____ and _____ certify the following to be true and accurate.

A. Domestic Partner Certification

We certify that we are domestic partners in accordance with the following criteria and eligible for benefits coverage under a group health benefit plan:

1. Are each eighteen (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 and intend to remain so indefinitely,
4. Are not married to anyone nor have had another domestic partner within the prior six months;
5. Are not related by blood closer than would bar marriage in the State of New York;
6. Share the same regular and permanent residence, with the current intent of doing so indefinitely; we affirm that the effective date of this domestic partnership is _____ and that this domestic partnership has been in existence for a period of _____ consecutive months, at least, prior to the date identified on the affidavit. We understand that documentation will be required;
7. Are jointly financially responsible for "basic living expense", defined as the cost of basic food, shelter, and any other expenses of a domestic partner which the partner qualified because of the domestic partnership. (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.); and
8. Were mentally competent to consent to contract when our domestic partnership began.
9. We can, upon request, provide evidence of joint responsibility. Joint responsibility may, but need not necessarily, be demonstrated by the existence of three or more of the following:
    a. A domestic partnership agreement;
    b. A joint mortgage or lease;
    c. Designation of his or her partner as a beneficiary for life insurance and retirement contracts;
    d. Designation of his or her partner as primary beneficiary in the Employee's will;
    e. Durable power of attorney for property and health care; and
    f. Joint ownership of motor vehicle, joint checking or joint credit account.

- We understand that domestic partners are subject to the other eligibility provisions of the benefit plan.
- We understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in a circumstance attested to in this affidavit.
- We agree to provide written notice to the payroll/personnel representative if there is any change of circumstances attested to in this affidavit within 30 days of the change by filing a statement of Termination of Domestic Partnership.
- After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed within six months following the filing of a State of Termination of Domestic Partnership with my payroll/personnel representative.
- We understand that Domestic Partners are not eligible for continuation of benefits under COBRA.
- Our domestic partnership (as defined in this section) has been in existence for at least (6) months prior to the effective date of this affidavit.
- We certify, under penalty of perjury, that the foregoing is true and correct. We, the undersigned employee and the Domestic Partner, understand that falsification of information contained in this Affidavit my lead to disciplinary action, up to and including immediate termination of the employee's employment, and may subject us to civil action to recover any losses, including reasonable attorney's fees incurred by Group or by its insurance carrier for benefits provided under the Medical Plan.

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

AFFIDAVIT OF DOMESTIC PARTNERSHIP

B. Partner Certification as a Tax-Qualified Dependent

Based on consultations with a tax advisor, I certify that the previously named person whom I am enrolling for coverage **is or is not** (circle one) my legal tax dependent under IRS Section 152. I agree to notify my employer immediately of any change in this tax status. I understand that coverage of the non-employee domestic partner/same sex spouse could result in additional imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes). I further understand that this coverage carries potential tax implications for the domestic partner/same sex spouse.

I understand that the Greater Tompkins County Municipal Health Insurance Consortium, BlueCross BlueShield, and ProAct are not currently obligated to provide, nor do they currently provide me or my employer with tax reporting, with respect to dues or benefits paid under the plan for my Domestic Partner.

C. Dependent Child Certification

I certify that my Partner's child or children named below meet the following requirements:

1. A parent-child relationship exists between the child or children and me.
2. The child or children is or are primarily dependent upon me for support.
3. The child or children is or are unmarried and reside(s) in my household and meet(s) the age eligibility requirements for the policy purchased by Group and is (are) dependent on me for at least 50% of his/her (their) support.
4. I assume full responsibility and control, including any and all debt incurred by the child or children.
5. I, or my Partner, have a court-appointed legal relationship with the child or children (i.e., adoption, guardianship, foster child), or my Partner is the biological parent of the child.

Partner's Dependent Children:

Last Name _____ First Name_____ MI ___ Date of Birth ___/___/_____

Last Name _____ First Name_____ MI ___ Date of Birth ___/___/_____

Last Name _____ First Name_____ MI ___ Date of Birth ___/___/_____

I understand that falsely certifying as to a dependent's eligibility or failure to inform my employer when a dependent no longer meets applicable eligibility requirements may result in disciplinary action, up to and including immediate termination of employment.

I affirm the statements made above are true and complete to the best of my knowledge.

_____ _____

Signature of Employee / Date | Signature of Partner / Date

_____ _____

Print Name | Print Name

_____ _____

Social Security # | Social Security #

Notary Seal: | Notary Seal:

Approved by Employer:_____

_____ _____

Signature of Employer Rep/ Date | Print Name/ Title