DECLARATION OF DOMESTIC PARTNERSHIP
Dependent and Life Event Verification

I. DECLARATION:

We, _____ and _____,
(Associate print name) (Domestic Partner print name)

Each certify and declare that we are domestic partners in accordance with the following criteria:

II. Status

1. We acknowledge our domestic partnership has been active for the past 12 months.
2. We acknowledge we have 30 days from the first anniversary of the domestic partnership date to initially enroll in benefits. Example: domestic partnership **began** on 1/6/2024, the initial enrollment window for the domestic partner is 1/6/2025-2/5/2024.
3. We acknowledge we have 30 days to make a change in benefits due to a qualifying life event.
4. We acknowledge we have the opportunity to enroll or make changes during the annual open enrollment period.
5. We affirm that this domestic partnership **began** on __/___/___.
6. We are each other's sole domestic partner, and we intend to remain so indefinitely.
7. Neither of us is married to or legally separated from anyone else nor had another domestic partner within the prior 12 months.
8. We are both at least eighteen (18) years of age or meet the age of consent in our state or residence; and mentally competent to contract.
9. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.
10. We are engaged in a committed relationship of mutual caring and support and are jointly responsible for our common welfare and living expenses. Our interdependence is demonstrated by submitting at **least one of the following dated within the past 12 months** (please check appropriate item and submit proof of item checked with this form):

    - ☐ Joint Utility Bill
    - ☐ Joint Vehicle Registration
    - ☐ Joint Mortgage or Lease Agreement
    - ☐ Joint documents from the Bank Account or Financial Institution
    - ☐ Driver's license listing common address (both associate and domestic partner must submit a copy of their driver's license)
    - ☐ Proof partner is designated as the primary beneficiary for existing life insurance, retirement benefits or under a partner's will.

11. We are not in this relationship solely for the purpose of obtaining benefits coverage.

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III. DEPENDENT CHILDREN OF DOMESTIC PARTNER:

We understand that dependent children of _____ are eligible for
(Domestic Partner print name)

Coverage when they are:

- Unmarried
- Primarily dependent on the associate for support and meet the age /school and all eligibility requirements of the plan benefits.

IV. CHANGE IN DOMESTIC PARTNERSHIP:

1. We have an obligation to notify our employer **by filing a Declaration of Termination of Domestic Partnership (if require proof of divorce)** if there are any change in our domestic partnership status as attested to in this Declaration that would terminate this Declaration (e.g., due to death of partner, a change in residence of one partner, termination of the relationship, etc.). We will notify our employer within thirty-one (31) days of such a change.
2. We understand that termination of this coverage (obtained because of completion of this Declaration) will be effective on the date after **the change in domestic partnership occurred / the date indicated on the Declaration of Termination of Domestic Partnership (if require proof for divorce)**, providing coverage has not otherwise terminated due to standard policy provision.

V. ACKNOWLEDGEMENT:

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fee and cost) due to any false statement contained in this Declaration or for failure to notify our employer of any changed circumstances as required in Section IV above. I, the undersigned associate, further understand that falsification of information in this Declaration, or failure to notify our employer of changed circumstances pursuant to Section IV above, may lead to disciplinary action against me, including discharge from employment.
2. We have provided the information in this Declaration for use by our employer for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree that our employer is not legally required to extend any such benefits. We understand that this information provided in this Declaration will be treated as confidential by **o**ur employer but will be subject to disclosure; a) upon the express written authorization of the undersigned associate, b) upon request of the insurer or plan administrator, or c) if otherwise required by law.
3. By sending in documents, I acknowledge the information I am submitting to prove eligibility for myself and/or my dependents is accurate. I understand that if I provide false information, I may be subject to disciplinary measures.

We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters. We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

_____ / / _____ / / .
Associate Signature Date of Birth Date

_____ / / _____ / / .
Domestic Partner Signature Date of Birth Date

Associate & Domestic Partner Address: _____.