

Employee's Name: \_\_\_\_\_

SSN: \_\_\_\_\_

**GTFF HEALTH PLAN**  
**AFFIDAVIT OF DOMESTIC PARTNERSHIP**

**SECTION ONE**

I and \_\_\_\_\_ are domestic partners and we:  
(Name of Domestic Partner)

- 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;
- 4) Are not married to anyone nor have had another domestic partner within the prior 31 days;
- 5) Are not related by blood closer than would bar marriage in the states of Oregon or Washington;
- 6) Share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
- 7) Are jointly financially responsible for "basic living expenses", defined as the cost of basic food, shelter, and any other expenses of a domestic partner which are paid at least in part by a program or benefit for 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);
- 8) Were mentally competent to consent to contract when our domestic partnership began.

**SECTION TWO**

- 1) I understand that my domestic partner is eligible for enrollment on the same terms as other dependents covered under the plan.
- 2) I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in circumstance attested to in this Affidavit.
- 3) I agree to provide written notice to the GTFF 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.
- 4) After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed until thirty one (31) days after the filing of a Statement of Termination.

SECTION THREE

- 1) We understand that the information contained in the Affidavit will be held confidential and will be subject to disclosure only upon the express written authorization or as required by law.
- 2) We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of a willful falsification of information contained in this Affidavit of Domestic Partnership.
- 3) (Applicable if the Group has a Section 125 Plan) We understand that under applicable federal and state income tax law, payments for health coverage of a domestic partner may not be eligible for treatment under the GTFF Section 125 Plan and that coverage of the non-employee domestic partner could result in additional imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes).
- 4) We understand that, in addition to this, the eligibility requirements of GTFF Health Plan for domestic partner coverage, there are terms and conditions of coverage set forth in the Service Agreement of each health care plan offered through GTFF Health Plan to which we agree to be bound.
- 5) We understand willful falsification of information contained in the Affidavit may result in our termination of enrollment by the GTFF Health Plan.
- 6) We also certify under penalty of perjury under the laws of the State of Oregon, that the foregoing is true and accurate to the best of our knowledge.

**(SIGNATURES MUST BE NOTARIZED)**

Signature of Employee:

Date:

Signature of Domestic Partner:

Date:

Address

County of Lane )

) ss

State of Oregon )

SUBSCRIBED AND SWORN before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public of Oregon

My Commission Expires