East End Health Plan

DECLARATION OF DOMESTIC PARTNERSHIP

Note: This form must be completed in full and forwarded to your District's Health Plan Coordinator

SECTION I. DECLARATION

We,_____ and _____
Employee - Print Name Domestic Partner - Print Name

certify and declare that we are domestic partners in accordance with the following criteria and, dependent on the participating school district's rules of eligibility, are eligible for health insurance under the East End Health Plan.

SECTION II. STATUS

We are each other's sole domestic partner and intend to remain so indefinitely.

1. We are in an affectionate, intimate relationship of mutual support, caring, and commitment. We share joint responsibility for the household.
2. Neither of us is married or legally separated from anyone else.
3. We are each at least eighteen (18) years of age and mentally competent to consent to this declaration.
4. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.
5. We have resided together in the same residence for at least the last twelve months and intend to do so indefinitely. (Proof of 12 months residency is required to be submitted along with this Form.)
6. At least four of the following are true (check those which apply) (Proof of at least two (two) of the following is required to be submitted along with this Form.):

- ☐ we have executed a domestic partnership agreement in a jurisdiction which authorizes such agreements;
- ☐ the employee has named his or her domestic partner as a beneficiary under his or her will, or the domestic partner has named the employee as a beneficiary under his or her will;
- ☐ the employee has granted his or her domestic partner powers under a durable power of attorney or the domestic partner has granted the employee powers under a durable power of attorney;
- ☐ the employee has named his or her domestic partner as a beneficiary on his or her life insurance policy, or the domestic partner has named the employee as a beneficiary on his or her life insurance policy;
- ☐ we have each designated each other as healthcare surrogates on a health care proxy statement;
- ☐ we have a joint bank account;
- ☐ we are cosigners of a lease or deed;
- ☐ we have a joint loan.

7. Neither of us has had a different domestic partner within the last 12 months from the date of the execution of this declaration (this condition does not apply if you had a domestic partner who died).

SECTION III. DEPENDENT CHILDREN OF DOMESTIC PARTNER

We understand that dependent children of _____ are eligible
Domestic Partner - Print Name
for coverage when they are:

1. Unmarried;
2. Primarily dependent on the employee (the employee must provide more than 50% of the child's support) for support;
3. Permanently residing in the employee's household;
4. Meet the age/school requirements of the plan for benefits; and
5. May be claimed by the employee and/or domestic partner as a dependent as defined in IRC Section 152.

Name of Child	Social Security Number	Sex	Date of Birth
	_____ - ____ - _____		____ / ____ / ____
Dependent of : ? Employee	? Domestic Partner		
Name of Child	Social Security Number	Sex	Date of Birth
	_____ - ____ - _____		____ / ____ / ____
Dependent of : ? Employee	? Domestic Partner		
Name of Child	Social Security Number	Sex	Date of Birth
	_____ - ____ - _____		____ / ____ / ____
Dependent of : ? Employee	? Domestic Partner		

SECTION IV. CHANGE IN DOMESTIC PARTNERSHIP

1. We agree to notify the enrolling school district if there is any change in our status as domestic partners as attested in this Declaration which would make the non-employee partner and/or any of his/her dependent children ineligible for the East End Health Plan. (for example, due to the death of partner, a change in joint - residence, termination of the relationship, etc.)

2. We will notify the enrolling school district within fourteen (14) days of such change in our status as domestic partners by filing a Declaration of Termination of Domestic Partnership (Declaration of Termination). The Declaration of Termination shall be on a form provided by the enrolling school district and shall affirm the domestic partner status terminated. The health insurance coverage will be terminated as of the end of the month of the date of the termination of the domestic partner status. A copy of the Declaration of Termination must be mailed to the other party within seven days of the filing of the Declaration of Termination.*

SECTION V. ACKNOWLEDGMENTS

1. We understand that any person/employer/company/insurer/claims administrator who suffers any loss due to any false statement contained in this Declaration may bring a civil action against either or both of us to recover their losses, including reasonable attorney's fees.
2. We have provided the information in this Declaration for use by the enrolling school district and the East End Health Plan for the sole purpose of determining our eligibility for domestic partner benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or pursuant to a court order.
3. 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 and accounting advice concerning such matters.

We affirm that assertions in this Declaration are true to the best of our knowledge. I (the employee) understand that false statements may require payment by me of claims incorrectly paid on behalf of my domestic partner listed above. I understand that false statements may result in disciplinary action by my employer or in other legal actions appropriate to the prosecution of insurance fraud.

We understand that this form is not an application for health insurance coverage and that the purpose of this form is to establish the eligibility of persons named herein for the coverage provided under the East End Health Plan.

Employee's Name	Social Security Number _____- _____-_____	Sex	Date of Birth _____/_____/_____
Employee's Signature: Date: _____/_____/_____			
Domestic Partner's Name	Social Security Number _____- _____-_____	Sex	Date of Birth _____/_____/_____
Domestic Partner's Signature: Date: _____/_____/_____			

EMPLOYEE AND DOMESTIC PARTNER'S ADDRESS:

Street Address		
City	State	Zip Code

Return this form in a sealed envelope to the School District's Health Plan Coordinator.

* Termination of coverage for domestic partners does not qualify that person for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).