UNIVERSITY OF NEW ENGLAND

INNOVATION FOR A HEALTHIER PLANET

AFFIDAVIT OF DOMESTIC PARTNERSHIP

_____
Employee Name

_____ _____
Home Address Social Security #

_____ _____
City, State Zip Birth Date

_____
Domestic Partner Name

_____ _____
Home Address Social Security #

_____ _____
City, State Zip Birth Date

A. DOMESTIC PARTNERSHIP DEFINITION:

A domestic partnership shall be deemed to exist between two persons of the same or opposite sex if both complete and sign this affidavit and attest to the following:

The Domestic Partner is at least eighteen (18) years of age or older;

Both parties are of legal age of consent and mentally competent to enter into a contract in the state in which they reside;

An intimate relationship exists between the parties whereby both parties holds the other out to the public as a spousal equivalent, each are the other's sole Domestic Partner and each intends to remain so indefinitely;

Both parties currently share a common residence, have shared said residence continuously for at least six (6) months and intend to do so indefinitely;

Neither party is married to anyone else and the parties are not related to each other by adoption, or blood to a degree of closeness which otherwise bars marriage in the state in which they legally reside (i.e. Employee's partner, sibling, certain extended family members);

Both parties are jointly responsible for each other's common welfare, and for each other's financial obligations;

It has been at least six (6) months since either of the two parties filed a statement of termination of a previous domestic partnership affidavit or has ended a legally recognized marriage.

Employer shall make the final determination of domestic partner status. Employer and the health plan administering benefits reserve the right to request documentation to verify domestic partnership status (e.g. documentation of shared, continual residency; documentation of joint financial responsibilities). However, such documentation may only be requested once per calendar year.

B. <u>ACKNOWLEDGEMENTS:</u>

We understand that any person or entity that suffers any loss due to any misstatement or false statement contained in this affidavit may bring a civil action against either or both of us to recover their losses, including reasonable attorney's fees, and we agree to assume our own and each other's resultant financial liability.

We understand that any misstatement or false statement contained in this affidavit including failure to provide updated information as required herein, may be grounds for immediate, and possible retroactive, termination of all benefits for either or both of us.

We have provided the information in this Affidavit for use by Employer and health plan administrator for the sole purpose of determining our eligibility for domestic partnership benefits.

Under applicable state and federal law, payments for benefit coverage for the Domestic Partner may result in tax liability for Employee and/or the Domestic Partner, depending on whether the domestic partner is a "dependant" for state and federal tax purposes.

Employer and health plan administrator reserves the right to terminate, modify, or adjust this policy at any time and in their sole discretion.

We understand that we are subject to the same terms and conditions, to the extent applicable, including periods of notice as all other employees and their dependents who are covered by or applying for benefits.

Unless legally required by state or federal law, or if Employer so chooses, continuation of coverage may not be available to domestic partners of COBRA eligible employees.

We agree to notify Employer if there is any change in our status as domestic partners as attested to in the Affidavit, which would make us no longer eligible for benefits. We will notify Employer, in writing, within five (5) business days of such change.

We understand this does not guarantee coverage for the Domestic Partner (and his/her dependents); in certain circumstances, (he/she/they) may be subject to the Discretionary Enrollment requirements in the Certificate of Coverage.

We understand this does not guarantee that dependents of the Domestic Partner will be eligible for coverage; this will be governed by the specific Certificate of Coverage.

C. <u>SWORN STATEMENT:</u>

We declare under penalty of perjury that all the foregoing information provided by us is true and correct and that all provisions of the Employer and health plan administrator's Domestic Partnership policy and eligibility criteria have been met.

_____ _____
Employee Signature Date

_____ _____
Domestic Partner Signature Date

_____ _____
Employer Representative Date