Affidavit of Domestic Partnership

I. DECLARATION

We,_____, and
(Print Name of Employee)

_____ being duly sworn under oath,
(Print Name of Domestic Partner)

do certify and declare that we are Domestic Partners in accordance with the following criteria and are eligible for health and dental insurance under the State Employee Benefits Program. We understand that in order for the Domestic Partner and Domestic Partner's children's expenses to be eligible for reimbursement under the State's flexible spending account program, these individuals must be tax dependents of the Employee.

II. DOMESTIC PARTNER CRITERIA

1. We are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for our common welfare.
2. We agree to financially support each other during the time of our Domestic Partner relationship by being jointly responsible for each other's necessities, including without limitation, food, clothing, housing, and medical care.
3. We are not legally married to anyone.
4. We are at least eighteen (18) years of age or older and are mentally competent to consent to this contract.
5. We are not related by blood closer than would bar marriage in our state of residence.
6. This relationship has been in existence for a period of at least twelve (12) consecutive months, and we have jointly shared the same residence for at least six (6) months.
7. Our relationship meets at least three of the following four conditions (please check those that apply, A-D):

☐ A. We have common or joint ownership of a residence (home, condominium, or mobile home).

☐ B. We have at least two of the following (please check which two apply):

- ☐ 1.) Joint ownership of a motor vehicle.
- ☐ 2.) Joint checking account.
- ☐ 3.) Joint credit account.
- ☐ 4.) Lease for a residence identifying both partners as tenants.
- ☐ 5.) Durable power of attorney for health care or financial management.

☐ C. The Domestic Partner has been designated as <u>the primary</u> beneficiary for at least one of the of the following (please check which one applies):

- ☐ 1.) The Employee's life insurance contract
- ☐ 2.) The Employee's will
- ☐ 3.) The Employee's retirement contract

☐ D. A "relationship contract" has been executed which obligates each of the parties to provide support for the other party and provides, in the event of the termination of the relationship, for a substantially equal division of any property acquired during the relationship.

Documentation may be required to prove the existence of any of the above-mentioned items. This affidavit will be valid for one calendar year.

III. CERTIFICATION OF DOMESTIC PARTNER AS A DEPENDENT

Please check one:

☐ Yes, my Domestic Partner qualifies as my dependent for federal income tax purposes as defined in Internal Revenue Code sec. 152.

I understand that on the basis of the above statements, the State will consider the above person my dependent for all federal income and employment tax purposes.

I agree to reimburse the State for any liability including, without limitation, taxes, penalties, or losses (including reasonable attorneys' fees) that the State may incur arising out of its reliance on this affidavit if it is untrue in any respect, or if I fail to provide notice required by section IV.

☐ No, my Domestic Partner does not qualify as my dependent for federal income tax purposes. I understand that I cannot submit claims for flex health or dependent care expenses of my Domestic Partner or my Domestic Partner's child.

IV. CHANGE IN DOMESTIC PARTNERSHIP

1. I, the employee, agree to notify my Human Resources Associate within thirty-one (31) days if there is any change in our status as Domestic Partners as attested in this Affidavit which would make the domestic partner and/or any of his/her dependent children ineligible for the State Employee Benefits Program (for example, due to death of a partner, a change in joint residence, termination of the relationship, etc.).

2. Upon notification, an Affidavit of Termination of Domestic Partnership shall be provided by my Human Resources Associate, which I will complete to affirm that the partnership is terminated. Domestic Partner coverage under the State's Employee Benefits Program will be terminated as of the end of the month in which the employee's Human Resources Associate receives the termination affidavit. No notice of the termination will be sent to the Domestic Partner, or the Domestic Partner's dependents, if any.

3. After termination of the Domestic Partnership, another Affidavit of Domestic Partnership cannot be filed with my Human Resources Associate until twelve (12) months have elapsed after which I may enroll my Domestic Partner in my health and dental insurance subject to the State's eligibility and enrollment rules.

4. I understand that when I enroll in health insurance and/or dental insurance my benefit elections will remain in effect until the end of the calendar year and I will not be able to make any changes until the next enrollment and change period **unless** I experience a qualified life event.

V. ACKNOWLEDGEMENTS

1. We recognize that Domestic Partner benefits are based on bargaining status and are not provided to all employees. We further understand that we must meet the eligibility requirements of the particular benefit plan(s) we are requesting. Last, we understand that the State will not provide COBRA rights to a Domestic Partner or his/her children if the partnership is dissolved, if the employee terminates employment, or if the Domestic Partner's dependents have an event that makes them ineligible for the employee's plan.

2. We understand that if both the "Employee" and "Domestic Partner" are State employees eligible for health and dental insurance, then **selection of family coverage under the Domestic Partner provision effectively waives any right of either party to single coverage benefits or contributions during the time the partnership is in effect**.

3. We understand that any person, employer, or company who suffers any loss because of false statements contained in this "Affidavit of Domestic Partnership" may bring civil action against either or both of us to recover their losses, including reasonable attorney fees.

4. We provide the information in this affidavit to be used by my Human Resources Associate for the sole purpose of determining our eligibility for Domestic Partnership benefits.

5. We understand that this Affidavit may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Affidavit, we should seek competent legal and accounting advice concerning such matters.

6. We have reviewed the information about Domestic Partner's health and dental benefits at the DAS Benefits website (https://das.iowa.gov/human-resources/employee-and-retiree-benefits).

VI. DEPENDENT CHILD/CHILDREN OF A DOMESTIC PARTNER

I, the above named Domestic Partner, certify that the following are my eligible dependent children:

Name	Date of Birth

VII. AFFIRMATION

We affirm, under penalty of perjury, that the statements in this affidavit are true to the best of our knowledge. We understand that this form is not an application for insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under the State's Employee Benefits Program.

(Print Name of Employee)	(Print Name of Domestic Partner)
(Signature of Employee)	(Signature of Domestic Partner)
(Employee's Date of Birth)	(Domestic Partner's Date of Birth)
(Date)	(Date)

Indicate if the Domestic Partner is also a State employee by providing the department name below:

Subscribed to and sworn to before me this _____day of_____, 20_____.

_____
(Notary Public Signature)