AFFIDAVIT OF DOMESTIC PARTNERSHIP

I. DECLARATION

Full Time
Part Time

Employee: ______________________________ ______________________
Last Name, First, Middle Initial Social Security Number

Domestic Partner: ______________________________ ______________________
Last Name, First, Middle Initial Social Security Number

____
Employee's/Domestic Partner's Home Address

- We provide this information to be used by the University for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that the information contained in this affidavit is confidential and will be subject to disclosure to those administering benefits, as otherwise required by law, or by the health insurance carrier that provides us coverage;
- We reside together in the same residence and have so resided for the last 12 months;
- We are each other's sole domestic partner and intend to reside together in the same residence indefinitely;
- We are jointly responsible for each other's common welfare and financial obligations*;
- We are both over 18 years of age and are mentally competent to consent to this contract;
- We are not related by blood to any degree that would bar us from marriage in New York State;
- Neither of us is legally married to any other person;
- Neither of us has terminated a Declaration of Domestic Partnership or its equivalent in any jurisdiction within 12 months immediately prior to signing this statement; and
- We have an exclusive mutual commitment similar to that of marriage and it is our intent that substantially all property acquired during our domestic partnership shall be considered joint property in the same manner as if we were married.

*Jointly responsible for each other's common welfare and financial obligations means the cost of food, shelter, and any other basic living expenses of a domestic partner. The individuals need not contribute equally or jointly to the costs of these expenses as long as they agree that both are responsible for the cost.

II. DOCUMENTATION

We are domestic partners who reside together in the same residence and are financially interdependent. We submit original documents of **three (3)** of the following items (at least two of the three items must be from List A as proof of financial interdependence). All documents must show they have been in existence at least 12 months.

Note: Original documents will be copied only to the extent necessary to document receipt and returned to you.

List A (2 items required from this list)	List B
Joint obligation of a loan	Joint bank account
Joint ownership of our residence	Joint credit or charge card(s)
Designated as beneficiary under the other's life insurance policy, retirement benefits, will, or executor of each other's will	Status as authorized signatory on the partner's bank account, credit card or charge card
Joint renter's or home owner's insurance policy	Other proof establishing economic interdependence
Joint lease agreement	
Health care proxy	
Legal document of an established Domestic Partner relationship	

III. CHANGE IN DOMESTIC PARTNERSHIP

We agree to notify the Human Resources Department if there is any change in our status as domestic partners or the dependency status of the children of the employee's domestic partner, as certified in this statement, which would make us no longer eligible for benefits. We will notify the College within thirty-one (31) days of such change by completing a Notice of Termination of Domestic Partnership with the Human Resources Department. The Notice of Termination of Domestic Partnership shall affirm the date that the domestic partnership status terminated.

IV. ACKNOWLEDGEMENTS

- We acknowledge that our domestic partnership has been entered into voluntarily;

- We understand that this affidavit may create between us certain contractual rights and legal obligations and that the University has encouraged us to seek independent legal advice about those rights and obligations;

- We understand that any additional cost incurred by the University as a direct result of enrolling a domestic partner and his/her children in the health care plans will result in a taxable benefit to the employee;

- We acknowledge that any health care or dependent care costs incurred by the domestic partner and/or dependent children cannot be reimbursed to the employee through his/her Flexible Spending Account(s), unless the domestic partner and/or dependent children meet established dependency requirements;

- We acknowledge that the domestic partner and children are not entitled to health care continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) if the employee terminates employment from Nazareth University, transfers to a benefit ineligible class, the domestic partnership ends, or if dependent children become ineligible for benefits.

- We acknowledge that registration of domestic partnership will be required for coverage under the health care plans effective with the open enrollment period preceding January 1st. New employees may apply upon hire or during any subsequent open enrollment periods;

- We declare, under penalty of perjury, that the statements and information provided herein are true and correct. We understand that falsely certifying eligibility, failing to file a Notice of Termination of Domestic Partnership form when a domestic partner relationship ends, or otherwise misstating, misrepresenting, or omitting facts relevant to eligibility, may bring a civil action against either or both of us. We further understand that any person, employer, or company who suffers any loss due to any false statements contained in this affidavit may subject us to civil and or criminal prosecution for benefits wrongly obtained and that we may become liable for such benefits and expenses associated with the recoupment (including reasonable attorney's fees). We acknowledge that any false statement could result in disciplinary action to the employee, including termination of employment;

- Nazareth University reserves the right to change or terminate any or all benefits, for any reason, at its sole discretion.

I am applying for the following benefits for my domestic partner:

Health Insurance:	o Yes	o No
Flexible Spending Account:	o Yes	o No
Dental Insurance:	o Yes	o No
Vision Insurance:	o Yes	o No
Long Term Care:	o Yes	o No
AFLAC Cancer Financial Protection:	o Yes	o No
College Facilities Privileges:	o Yes	o No
Tuition Remission Program*:	o Yes	o No
Life Insurance	N/A	

*Must meet established eligibility requirements to be eligible for this program.

__________________________ ________________________
Employee's Signature Date

__________________________ ________________________
Domestic Partner's Signature Date

__________________________ ________________________
Notary Seal and Signature Date

TO BE COMPLETED BY HUMAN RESOURCES

o Approved by Human Resources o Declined by Human Resources

__________________________ ________________________
Director of Human Resources Date