Declaration of Domestic Partnership

DECLARATION

We, _____ and _____ certify and declare that we are domestic partners in accordance with the following criteria and eligible for health insurance benefits under The Christ Hospital Health Network health insurance program.

STATUS

1. We affirm that this Domestic Partnership began on or about ____/____/____
2. We are each other's sole domestic partner and intend to remain so indefinitely.
3. Neither of us is married or legally separated from anyone else.
4. We are each at least eighteen (18) years of age and mentally competent to consent to this declaration.
5. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.
6. We reside together in the same residence and intend to do so indefinitely.
7. At least THREE of the following are true (check those which apply):

   _____ We have lived together continuously for 12 months;

   _____ We have a joint bank account;

   _____ We are cosigners of a lease or deed;

   _____ We are named on the same car insurance policy;

   _____ We have driver's licenses with a common address;

   _____ 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 named his or her domestic partner as a beneficiary on his or her life insurance policy, or the domestic partner has named the employee beneficiary on his or her life insurance policy; and

   _____ We have executed a domestic partnership agreement in a jurisdiction which authorizes such agreements.

8. 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).

CHANGES IN DOMESTIC PARTNERSHIP

1. We agree to notify The Christ Hospital Health Network as required by this Section III if there is any change in our status as domestic partners as attested in this Declaration which would make the domestic partner ineligible for The Christ Hospital Health Network Health Network health insurance programs (for example, due to the death of partner, change in joint residence, termination of the relationship, etc.)
2. We will notify The Christ Hospital Health Network within thirty (30) days of such change in our status as domestic partners by written notification of termination of the domestic partnership. We understand that this notification shall affirm that the domestic partner status is terminated and that termination of insurance coverage will be effective on the date the relationship ends as indicated in the termination notification.

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 civil action against either or both of us to recover their losses, including reasonable attorney's fees.
2. We understand that any person/employer/company/insurer/claims administrator who suffers any loss due to our failure to report a termination in our domestic partner status within 30 days of our ineligibility as required in Section III above may bring civil action against either or both of us to recover their losses, including reasonable attorney's fees.
3. We have provided the information in this Declaration for use by The Christ Hospital Health Network for the sole purpose of determining our eligibility for domestic partner benefits. We understand that this information will be held confidential but subject to disclosure;

a. Upon the express written authorization of the undersigned employee,
b. Upon request of the insurer or plan administrator, or
c. If otherwise required by law.

4. 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 matter.

5. We understand that benefit premiums are deducted from the employees' paycheck on an after-tax basis for the cost of the benefit premium for the domestic partner. Also that premiums paid by The Christ Hospital Health Network on behalf of the domestic partner are taxed to the employee as Imputed Income.

6. We further understand that if the Domestic Partner is employed, and medical benefits are available through that employer, the Domestic Partner is not eligible for medical benefits under a TCHHN medical plan.

We declare, under penalty of perjury, that the assertions in this Declaration are true to the best of our knowledge. We understand that this form is not an application for health insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under The Christ Hospital Health Network's health insurance programs.

Name of Spouse/Domestic Partner employer_____

Is Spouse/Domestic Partner eligible for benefits at their job? **YES** ☐ **NO** ☐

Employee ID#: _____

_____	_____	_____
Employee Signature	Date of Birth	Date
_____	_____	_____
Domestic Partner Signature	Date of Birth	Date
_____	_____	
Domestic Partner SS#	Male/Female	

Employee & Domestic Partner Address:

_____

_____

_____

NOTARY:

The forgoing statement was acknowledged before me

this _____day of _____, _____(year)

by _____
(Employee Name)

_____
Signature of Notary Public

My commission expires: _____
(Date)

Notary Stamp: