DUTCHESS EDUCATIONAL HEALTH
INSURANCE CONSORTIUM (DEHIC)

AFFIDAVIT OF DOMESTIC PARTNERSHIP

STATE OF_______________)
COUNTY OF_____________) SS:

The undersigned, being duly sworn, states under penalty of perjury as follows:

1. ____________________, is enrolled in the DEHIC Health Insurance Plan (hereinafter "Enrollee"). ____________________ is the domestic partner of the Enrollee (hereinafter "Partner").

2. We are both eighteen years of age or older.

3. We are both unmarried. If either of us has been married, we submit with this affidavit evidence of the termination of the marriage.

4. We are both financially interdependent.

5. We are not related by blood in a manner that would bar marriage under the laws of the State of New York.

6. We are each other's sole domestic partner, have been so for at least six (6) months prior to the date of this affidavit, and intend to remain so indefinitely. We are in a relationship of mutual support, caring and commitment, and have assumed responsibility for each other's welfare.

7. We have been living together in the same residence on a continuous basis for at least six (6) months prior to the date of this affidavit and intend to continue to do so indefinitely.

8. Neither of us has been in a different domestic partner relationship within the last six (6) months.

9. We have submitted with this affidavit proof of three (3) or more of the following checked items, which shall serve as true documentation of our domestic partner status:

- ☐ Cohabitation (e.g., a driver's license, a tax return, or other sufficient proof as determined by DEHIC)*
- ☐ Registration of domestic partnership**
- ☐ Joint bank account
- ☐ Joint credit or charge card
- ☐ Joint obligation on a loan
- ☐ Joint ownership of residence
- ☐ Joint tenancy on a lease of residence or shared rental payments of residence
- ☐ Shared common household expenses (e.g., utility bills, phone bills, etc.)
- ☐ Joint ownership of vehicle or major items of personal property
- ☐ Wills having each other as executor and/or beneficiary
- ☐ Designation of one of the undersigned as beneficiary under the other's life insurance policy
- ☐ Designation of one of the undersigned as beneficiary under the other's retirement benefits plan
- ☐ Mutual grant of authority as health care proxy between the undersigned
- ☐ Mutual grant of durable power of attorney between the undersigned
- ☐ Status of one of the undersigned as authorized signatory or guarantor on the other's credit card, charge card or bank account
- ☐ Joint ownership of holding of investments
- ☐ Shared household budget for purposes of government benefits
- ☐ Status of one of the undersigned as payee of the other's government benefits
- ☐ Joint responsibility or shared expenses for child care
- ☐ Affidavit of creditor or other individual able to testify to partners' financial interdependence

*Proof that Enrollee and Partner have been living in the same residence on a continuous basis for at least six (6) months prior to the date of this affidavit is required.

**If registration by a government entity in New York State is available as of the date of this affidavit, proof of registration is required.

10. Our domestic partnership has been freely entered based upon our mutual commitment to each other that is not motivated by an effort to qualify for insurance coverage.

11. All of the information submitted with this affidavit is accurate to the best of our knowledge and is not false or misleading as to any material aspect.

I, ___________________, the Enrollee, agree that I will promptly file a Termination of Domestic Partnership Form with my employer's business office if my partner and I no longer meet the qualifying criteria for Domestic Partnership set forth above.

The undersigned acknowledge that any false or misleading statement made in this affidavit or otherwise in order to receive benefits may constitute insurance fraud. The undersigned jointly and severally agree to pay DEHIC on demand all expenses or damages whatsoever, including but not limited to claims expenses and reasonable attorneys fees, caused by or resulting from the inclusion of any false or misleading statement, documents or information in this affidavit.

____
Print Name (Enrollee)

____
Address

____
Address

____
Signature

____
Date

Sworn to before me this _____
Day of ____________, 201__

____
Notary Public

Print Name (Partner)

Address

Address

Signature

Date

Sworn to before me this _____
Day of ____________, 201__

Notary Public

For Business Office Completion:

	Yes	No
Required Documentation Submitted	☐	☐
Approved as to Form	☐	☐

Authorized Signature

Date:________________________

DUTCHESS EDUCATIONAL HEALTH INSURANCE CONSORTIUM
(DEHIC)

TERMINATION OF DOMESTIC PARTNERSHIP
(To be filed with Employer promptly upon termination)

1. I ________________________________ certify that:
   Name of employee (please print)

   I ________________________________, and ________________________________
   Name of employee (please print) Name of domestic partner (please print)

   have terminated our domestic partnership.

2. I affirm that the effective date of termination of this domestic partnership was

   ______________________________(Date).

3. I represent and promise that if I have not already done so, I will ensure that a copy of this termination statement is personally delivered to my former domestic partner or mailed to the last known address of my former domestic partner, within seven days of this date. I accept sole responsibility to provide this notice to my former domestic partner and acknowledge that my employer will not do so.

4. NOTICE: TERMINATION OF A DOMESTIC PARTNERSHIP WILL RESULT IN TERMINATION OF HEALTH INSURANCE COVERAGE FOR THE FORMER DEPENDENT DOMESTIC PARTNER.

5. I affirm that the statements in this notice are true to the best of my knowledge. I understand that false statements may cause damage for which I will be responsible, including but not limited to repayment by me of claims or premiums incorrectly paid. I further understand that false statements may result in disciplinary action by my employer and may constitute insurance fraud.

________________________________ ________________________________
Signature of employee/enrollee Date

Sworn to before me this ______
Day of ________________, 2010

____
Notary Public

________________________________ ________________________________
Business Office/Human Resource Signature Date