

AFFIDAVIT OF SAME-SEX DOMESTIC PARTNERSHIP
Group Medical and Dental

Group Name: SURA/Jefferson Science Associates

Note: Make a copy of this document for your records and attach the original to your Group Membership Application Form.

Employee Name: _____
Social Security #: _____ Birth Date: _____
Home Address: _____
Domestic Partner Name: _____
Social Security #: _____ Birth Date: _____
Home Address: _____

I, _____ certify that I reside, together with, _____ as a non-married cohabiting couple, sharing a common legal residence, and have done so for a minimum of twelve (12) months prior to the application of Domestic Partner coverage; and intend to cohabit indefinitely, sharing the common necessities of life.

We, the undersigned, hereby attest to the following:

1. The effective date of this Domestic Partnership was _____ and each party is the sole Domestic Partner of the other.
2. We are at least eighteen (18) years of age.
3. We are both of the same gender.
4. We are not related by blood or by adoption and are mentally competent to consent to contract.
5. We are not married to anyone; nor have either one of us had another/different Domestic Partner within the most recent 12 consecutive month period.
6. We are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for our common welfare and share basic living expenses.
7. Neither party has filed a Termination of Domestic Partnership within the preceding 12 months.

OR

As an alternative to the foregoing, we attest that we have entered into a civil union or same-gender marriage performed and recognized in the state in which we reside, which is the state of _____.

We agree to renew this Affidavit of Domestic Partnership annually or upon the written request of SURA Jefferson Lab.

I agree to notify my Employer if there is any change in circumstances, which requires the termination of the named Domestic Partner as soon as such event occurs, but not later than thirty (30) days of such change. Further, I agree to file a Statement of Termination of Domestic Partnership as written documentation to my Employer. Such Statement shall affirm under penalty of perjury that the Partnership is terminated and that a copy of the Statement of Termination of Domestic Partnership has been mailed to the other partner.

After such termination I, _____ understand that I cannot file another Affidavit of Domestic Partnership with my Employer, for purposes of plan enrollment, until at least twelve (12) months following the date of the Statement of Termination of Domestic Partnership filed with my Employer.

We understand that any persons, employer, company or other party who suffers any loss because of a false statement contained in this Affidavit of Domestic Partnership has right to bring civil action against us, named herein, to recover their losses including reasonable attorney's fees and other related expenses.

We provide the information in this Affidavit to be used by my Employer for the sole purpose of determining my eligibility for Domestic Partnership dependent benefits.

We attest that the following children are presently living with us in our home and we claim them as financially dependent for tax purposes and are entitled to claim a deduction on for each of the following children:

Child's Name	Social Security Number	Date of Birth

SWORN STATEMENT

We declare that all the foregoing information provided by us is true and correct, and that all provisions of this Statement have been met.

We understand that:

- (1) Any entities or persons, including, but not limited to SURA/Jefferson Science Associates group insurance carriers who suffer any loss because of any false statements contained in this Statement may bring a civil action suit against us to recover their respective losses, including reasonable attorney's fees; and
- (2) If there is any change in the information certified in this statement of Domestic Partnership that would make the Domestic Partner ineligible, the employee must file a Termination of Domestic Partnership form within 30 days of the change, and
- (3) Coverage for the Domestic Partner and eligible dependents of the Domestic Partner will be as follows:
 - Upon the firm's initial enrollment, provided all Domestic Partnership eligibility requirements are satisfied and approved by SURA /Jefferson Science Associates group insurance carriers.
 - A newly hired Subscriber may enroll a Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by SURA Jefferson Science Associate's group insurance carriers. The Effective Date of coverage will be in accordance with any applicable waiting period in place by SURA/ Jefferson Science Associates and/or the group insurance carriers.
 - In the case where a SURA/Jefferson Science Associates participating employer has an Open Enrollment Period, an existing Subscriber may enroll the Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by the applicable insurance carrier. Eligibility for enrollment other than during Open Enrollment Period will be in compliance with the insurance carrier's Late Enrollee policy.
 - In the case where the SURA/Jefferson Science Associates participating employer has no Open Enrollment Period, eligibility will be in compliance with the insurance carrier's Late Enrollee policy.

We agree to notify the Employer if our domestic partnership no longer meets the criteria established herein.

Employee Signature

Domestic Partner Signature

State of _____

County of _____

On this _____ day of _____, 20____, before me personally appeared _____ and _____, to me known to be the persons described herein, and who executing the foregoing, and swore to its truth.

Before me, _____
Notary Public Signature and Commission Expiration Date

SURA Jefferson Lab accepts this AFFIDAVIT OF DOMESTIC PARTNERSHIP,
By: _____ Title: _____ Date: _____