



AFFIDAVIT OF DOMESTIC PARTNERSHIP

School District _____ Employee ID# _____

I, (*print name of employee*) _____, certify that I and
(*print name of domestic partner*) _____

are and have each been the other's partner in a domestic partnership, as defined below. For purposes of this affidavit, a "domestic partnership" is one consisting of two persons in which the following applies:

1. Each domestic partner is at least 18 years of age;
2. They are each other's sole domestic partners living together in a spousal equivalent relationship;
3. The domestic partners share a close relationship and are responsible for each other's common welfare;
4. **To Apply During Open Enrollment Period:**
Jointly shared the same permanent residence for at least six (6) months immediately preceding the date of this affidavit and intends to continue to do so indefinitely. Please indicate how long you have lived together: _____.
5. **To Apply Outside Open Enrollment Period:**
Jointly shared the same permanent residence for six (6) months immediately preceding the date of this affidavit and applied for coverage within 31 days of the six month anniversary date. Please indicate date you began living together: _____.
6. The domestic partners are jointly financially responsible for basic living expenses including food, shelter and medical expenses;
7. Neither domestic partner is legally married to anyone; and
8. The domestic partners are not related by blood closer than would bar marriage in the state they reside in.

This affidavit terminates upon the death of the signing employee's domestic partner or by a change in circumstances attested to in this affidavit. The signing employee must notify OEA Choice Trust within thirty (30) days after such death or change, by completing a Change Of Information Form. After filing the Change Of Information Form with OEA Choice Trust, the employee may not file a new Statement of Domestic Partnership for the purpose of enrolling a new partner for six (6) months from the date such statement is received by OEA Choice Trust.

Notice: Signing this affidavit may or may not have legal and or tax implications affecting relations between domestic partners beyond the extension of medical, dental or vision insurance coverage for which it is intended. If you desire further information concerning the possible legal or tax consequences of signing this form, please consult an attorney and or income tax professional.

I attest that the certification I have provided herein is true and correct to the best of my knowledge.

(Employee's signature)

(Date)