Affidavit of Domestic Partnership

1. I, (employee name) _____ and (domestic partner)_____

   reside together and intend to do so indefinitely, at (address) _____ and share the common necessities of life. By signing this Affidavit for enrollment of a Domestic Partner in the County's medical plan, we agree that we both are economically responsible to third parties for the common necessities of life, defined as food, shelter and medical care, and shall remain the case for expenses incurred during the period that the non-employee domestic partner is covered by the County,

2. We affirm that the effective date of this domestic partnership is (date) _____

3. We are not married to anyone. Each of us understands that in addition to the eligibility requirements of the County for domestic partner coverage, there are terms and conditions of coverage set forth in the service agreement of each health care plan offered through the County. Each of us acknowledge that, depending on the health plan we select, the applicable service agreement may include, for example and without limitation: (1) a requirement that each of us arbitrate any and all claims, including malpractice claims, against the health care plan we choose and its related organizations and providers; and (2) the right of the health care plan to terminate coverage on the grounds set forth in the service agreement, including, without limitation, termination of coverage due to fraud or misrepresentation of eligibility. By executing this Affidavit each of use agrees to be bound by the terms and conditions of coverage of the health care plan selected, as set forth in the applicable service agreement, including the arbitration clause, if any.

4. We are at least eighteen (18) years of age or older.

5. We are not related by blood closer than would bar marriage in the State of California and are mentally competent to consent to contract.

6. We are each other's sole domestic partner and intend to remain so indefinitely, and are responsible for our common welfare.

7. We agree to notify the County if there is any change of circumstances attested to in this affidavit within thirty (30) days of change by filing a Statement of Termination of Domestic Partnership. Such termination statement shall be on a form provided by the County and shall affirm under penalty of perjury that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner.

8. After the effective date of termination, I, (employee) _____understand that another Affidavit of Domestic Partnership cannot be filed until six (6) months after a statement of termination of the previous partnership has been filed with the Employee and Public Services Department, Benefits Division.

9. We understand that any persons/employer/company who suffer any loss because of a false statement contained in an Affidavit of Domestic Partnership may bring a civil action against us to recover their losses including reasonable attorney's fees.

10. We provide the information in this Affidavit to be used by the County for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or pursuant to a court order.

11. We affirm, under penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge.

Please Note: The deduction for your domestic partner is not a pre-tax qualified deduction. Since this is not a pre-tax qualified deduction, you will be assessed imputed taxable income on your W2 tax statement at the end of the year that needs to be reported when you file taxes. We recommend that you speak to a qualified tax specialist or accountant if you have any additional questions.

Date	Employee Name & Signature	Date of Birth
Date	Domestic Partner Name & Signature	Date of Birth