

Affidavit of Domestic Partnership

Samaritan Entity _____ Employee ID# _____

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

_____ (*print name of domestic partner*)

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

1. Both are at least 18 years of age.
2. Are responsible for each other's welfare and are each other's sole domestic partners;
3. Are not married to anyone and have not had a spouse or another domestic partner within the prior six months. If previously married, the six-month period starts on the final date of the divorce.
4. Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
5. Have jointly shared the same regular and permanent residence for at least six months; and
6. Are jointly financially responsible for basic living expenses defined as: cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

TO APPLY WHEN NEWLY ELIGIBLE FOR BENEFITS OR DURING OPEN ENROLLMENT:

We have shared the same permanent residence for at least six months immediately preceding the date of this Affidavit and intend to continue to do so indefinitely.

Please indicate how long you have lived together: _____

TO ENROLL OUTSIDE OF A NEW BENEFIT PERIOD OR OPEN ENROLLMENT:

We have jointly shared the same permanent residence for six months immediately preceding the date of this Affidavit and are presenting this Affidavit to enroll in insurance benefits within 31 days of the six month anniversary date. *Please indicate the date you began living together:* _____

We certify under penalty of perjury, under our State laws, that the foregoing is true and correct. If premiums were incorrectly assessed due to willful falsification on this Affidavit of Domestic Partnership, we will be responsible for returning the reimbursed funds back to Samaritan Health Services. In addition, a civil action may be brought against us for any losses, including reasonable attorney's fees, arising from such falsification. Willful falsification of information may also lead to corrective action, up to and including discharge from employment.

Employee Signature: _____ Date _____

Domestic Partner Signature: _____ Date: _____

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 Samaritan Human Resources within 31 days after such death or change by completing a Termination of Domestic Partnership Form. After submitting the form, the employee may not file a new Affidavit of Domestic Partnership for the purpose of enrolling a new partner for 6 months from the date the termination form is received by Human Resources.

Note: Insurance premiums for domestic partnership coverage are post tax, and the Federal government requires that the cash value of the insurance be taxed. Please ask your Human Resources department for information regarding the cost of this coverage.