

## Attachment A: Affidavit of Domestic Partnership

The undersigned, begin duly sworn depose and declare as follows:

We are both eighteen years of age or older and unmarried. If either or both of us has been married, we submit evidence of the termination of the marriage.

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

We are each other's sole domestic partner, have been so for at least six 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.

We have been living together on a continuous basis for at least six (6) months prior to the date of this affidavit. One of us is enrolled in an employer group health insurance program. Neither of us has been registered as a member of another domestic partnership within the last six (6) months.

I, the enrollee, affirm that I will file a Termination of Domestic Partnership form within thirty (30) days of the date I/my partner no longer meet one or more of the qualifying criteria set forth above.

I, the enrollee, understand that any false or misleading statement made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my partner and/or other legal actions appropriate to the prosecution of insurance fraud.

_____ Print Name (Enrollee)	_____ Print Name (Partner)
_____ Address	_____ Address
_____ Date of Birth	_____ Date of Birth
_____ Signature	_____ Signature

Sworn to before me this day of  
NOTARY PUBLIC

**HR Use Only:**  
Date Received: \_\_\_\_\_ By (Print Name) \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

## Attachment A: Proof of Six (6) Months Residency

To enroll your domestic partner in your employer health insurance benefits program, you must submit a copy of one item of proof that you and your partner have resided together for at least six (6) months. The proof may be one document with both names or two separate documents that show the residence of each partner. The following is a list of some items that can be used to demonstrate proof of residency. You may submit a copy of another document that proves residency began at least six months ago.

- Driver's License
- Auto Registration
- Lease Agreement
- Mortgage Agreement
- Tax Return
- Bank Statement
- Passport
- Insurance Benefits Statement
- Paycheck stub
- Utility Bill
- Telephone Bill
- Joint Membership (eg. Church or family association)
- Registration as a domestic partnership in the municipalities that have established such a procedure (e.g. New York City, Rochester, Ithaca)

## Attachment A: Affidavit of Financial Interdependence

The undersigned, being duly sworn, depose and declare as follows:

We are domestic partners who reside together and are financially interdependent. We submit original documents of two (2) of the following items (at least one (1) of the two (2) items must be from List A) as proof of our financial interdependence:

(Note: Original documents will be copied only to the extent necessary to document receipt and returned to you.)

### List A

- Joint obligation on a loan (including an affidavit representative by creditor for a personal loan)
- Joint ownership of our residence
- Joint renters' or home owner's insurance policy
- Joint responsibility for childcare (e.g. school documents, guardianship)
- Designated as beneficiary under the other's life insurance policy, retirement benefits account, will, or executor of each other's wills
- An affidavit by a creditor or other person able to testify to partner's financial interdependence
- Mutually granted durable power of attorney

### List B

- Joint bank account
- Joint credit or charge card(s)

### List A (continued)

- Designation of one partner as the payee for the other's government benefits
- Joint ownership or holding of investments
- Joint ownership or lease of a motor vehicle
- Both listed as tenants on the lease of our shared residence
- Mutually granted authority to make health care decisions (e.g. health care power of attorney)
- Share a household budget for the purpose of receiving government benefits
- I claim my partner as a dependent for federal tax purposes

### List B (continued)

- Status as authorized signatory on the partner's bank account, credit cards, or charge card
- Other proof establishing economic interdependence

**NOTE:** Proof submitted must show financial interdependence for at least six (6) months.

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Print Name (Enrollee)

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Address

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Date of Birth

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Social Security Number

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Signature

---

Print Name (Partner)

---

Address

---

Date of Birth

---

Social Security Number

---

Signature

Sworn to before me this day of  
NOTARY PUBLIC

## Attachment B: Statement of Change to Domestic Partnership Status

**Please Print:**

I, \_\_\_\_\_, certify and declare that:  
(Employee's Name)

**Termination of Domestic Partnership:**

1. As of \_\_\_\_\_, \_\_\_\_\_ and I are no longer  
(mo/day/yr) (domestic partner's name)  
domestic partners.
2. I make and file this Statement of Termination of Domestic Partnership with Saratoga Hospital on \_\_\_\_\_.  
(mo/day/yr)

I understand that:

- a. Health/RX, Dental, and Vision coverage for my domestic partner and his/her dependents (if applicable) as well as the Courtesy Discount will end on the date in which the domestic partnership ended.
- b. I will be responsible for paying all premiums for benefits for all pay periods in which my domestic partner and his/her dependents (if applicable) had coverage.
- c. A copy of this document will be sent by Saratoga Hospital Human Resources to my former domestic partner at his/her address listed below along with any COBRA documentation (if applicable):

\_\_\_\_\_  
(# and street address) (City) (State/Zip Code)

**Marriage:**

1. As of \_\_\_\_\_, \_\_\_\_\_ and I are married.  
(mo/day/yr) (domestic partner's name)

I understand that:

- a. I must provide Human Resources with a copy of my marriage license.
- b. I must complete a marital status change request in Ultipro to change my marital status from single to married
- c. **If changing my name**, I must provide Human Resources with a copy of my new social security card and professional license (if applicable).
- d. **If changing my name**, I must complete a name change request in Ultipro.

I certify that the above information is correct.

\_\_\_\_\_  
(Employee's Signature) (Date)

**HR Use Only:**

Date Received: \_\_\_\_\_ By (Print Name) \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

## Attachment C: Annual Recertification of Domestic Partnership

**Please Print:**

\_\_\_\_\_  
(Employee's Name) (Domestic Partner's Name)

We certify that:

- We are still each other's sole domestic partners
- Neither of us are legally married to anyone
- We have been living together on a continuous basis for the last year (or as of date of previous domestic partnership affidavit completion)

We understand that:

- We must notify Human Resources if there is any changes in our status as domestic partners including marriage or termination of domestic partnership. We will notify Human Resources within thirty (30) days of such change by filing a Statement of Change to Domestic Partnership Status.
- Any false or misleading statements made in order to receive benefits for which we do not qualify for will subject me to financial responsibility for any benefits paid on behalf of my partner and/or other legal actions appropriate to the prosecution of insurance fraud.

We certify that the above information is correct.

\_\_\_\_\_  
(Employee's Signature) (Date)

\_\_\_\_\_  
(Domestic Partner's Signature) (Date)

**HR Use Only:**

Date Received: \_\_\_\_\_ By (Print Name) \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_