



Affidavit of Domestic Partnership

Instructions: Please complete this form to certify your domestic partnership for purposes of benefits eligibility. Both partners must sign and date this affidavit. Supporting documentation may be requested by Human Resources.

Section 1 – Certification of Domestic Partnership

We, the undersigned, hereby certify that we are domestic partners in accordance with one of the following:

Option A: We satisfy the criteria for recognition as domestic partners under applicable state law.

Option B: We satisfy all of the following criteria:

- Both of us are at least eighteen (18) years of age and are unmarried.
- We are not related by blood in any way that would prohibit lawful marriage.
- We have mutually assumed responsibility for each other’s welfare and financial support.
- We share a common residence and live together as a couple in the same household.
- We are each other’s sole domestic partner.
- We can provide evidence of joint financial responsibility if requested.

Section 2 – Acknowledgment of Termination and Benefit Eligibility

We acknowledge that if, at any time, we no longer meet one or more of the criteria listed above, we will no longer be considered domestic partners for benefits purposes. We agree to promptly submit an Affidavit of Termination of Domestic Partnership to the Human Resources Department. We understand that upon termination, the Domestic Partner and any dependents will immediately cease to be eligible for coverage under the company’s benefit programs.

Section 3 – Declarations

We declare under penalty of perjury that all information provided in this affidavit is true, complete, and correct to the best of our knowledge and belief. I, the Enrollee, further understand that any false or misleading statements made to obtain benefits for which I am not eligible may result in personal financial responsibility for any benefits paid on behalf of my domestic partner and/or their dependents; and may subject me to disciplinary action, up to and including termination of employment.

Section 4 – Partner Information

Employee (Enrollee)	Domestic Partner
Full Name: (First, M.I., Last)	Full Name: (First, M.I., Last)
Date of Birth:	Date of Birth:

Section 5 – Address of Residence Shared by Both Domestic Partners

Address:		
Address Continued:		
City:	State:	ZIP:

Section 6 – Signatures

Signature – Employee (Enrollee):	Date:
Signature – Domestic Partner:	Date:

For Human Resources Use Only

HR Representative Name:	Date Received:
Verification Completed By:	Date Processed: