Marion County

AFFIDAVIT OF DOMESTIC PARTNERSHIP

SECTION I

Employee Name: _____

Division/Department: _____ Work Phone: _____

SECTION II

I, _____, certify that:
(Employee Name)

My domestic partner is _____ and we reside
(Name of Domestic Partner)

together as a non-married couple at _____
(Address)

_____

The effective date of this domestic partnership (the date we began living together) is _____.
(Month and Year)

In relationship to this domestic partnership, I affirm that my partner and I meet all the criteria described below:

1. Are 18 years of age or older;
2. Are not legally married to anyone;
3. Are each other's sole domestic partner living together in a spousal equivalent relationship;
4. Have shared the same regular permanent residence for at least twelve (12) months immediately preceding the date of this Affidavit of Domestic Partnership, and intend to continue to do so indefinitely;
5. Are financially interdependent and jointly responsible for "basic living expenses"*; and
6. Are not related by blood so close as to bar marriage in the State of Oregon and are mentally competent to consent to contract when our domestic partnership began.

* For purposes of this Affidavit of Domestic Partnership (Affidavit), "Basic living expenses" means the cost of basic food, shelter and other expenses. You and your domestic partner need not contribute equally or jointly to the costs of these expenses as long as you agree that both are responsible for the cost.

SECTION III

A. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change in circumstances attested to in this Affidavit.

B. I agree to notify Human Resources - Employee Benefits within 31 calendar days if there is any change of circumstances attested to in this Affidavit by submitting a Statement of Termination of Domestic Partnership.

C. After such termination, I understand that an application to add a new domestic partner cannot be filed earlier than twelve (12) months from the date a statement of Termination of Domestic Partnership was submitted.

Continued on Reverse →

SECTION IV

I understand that the information in this Affidavit will be used by Marion County for the sole purpose of determining eligibility for obtaining benefits and that any other use of the information will be subject to disclosure only upon my express written authorization or if otherwise required by law.

I understand that signing this Affidavit may have legal implications beyond the extension of insurance coverage for which it is intended.

I understand that it is my responsibility to provide Marion County with documents establishing that the above-named person is my eligible domestic partner if the county requests such documentation. If I do not produce documentation within 31 calendar days of the request, Marion County may elect to retroactively rescind my dependent coverage, and I may be required to reimburse the county for any expenditure made by the county for the above named domestic partner, including but not limited to premiums, medical claims, administrative charges, and attorney's fees.

I understand that any person/employer/company who may suffer any loss because of a false statement contained in this Affidavit may bring a civil action against me to recover their losses including reasonable attorney's fees.

I understand that inclusion of false or misleading information in this Affidavit may lead to disciplinary action up to and including discharge from employment, and I attest that the certification I have provided herein is true and correct.

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

_____ _____

Employee's Signature Date

_____ _____

Human Resources - Employee Benefits Approval Date

A Marion County 'Health Plans Enrollment/Change Form' must be submitted with this Affidavit.

Complete & send to Human Resources - Employee Benefits within 30 days of above event or new hire.