



AFFIDAVIT OF DOMESTIC STATUS

Please complete and sign below upon hire and for all subsequent changes in status:

Section I Domestic Status

Name: _____ Date: _____

PLEASE PRINT

I Certify my status as being:

- A. Single, Divorced or Widowed: _____
- B. Married: _____ Date of Marriage: _____ Name of Spouse: _____
- C. With a Domestic Partner _____ Date of Union: _____ Name of Domestic Partner: _____

To qualify for Domestic Partner coverage all of the following conditions must be met:

1. share the same residence for a period of no less than six consecutive months;
2. have a close and personal relationship with the intent for this relationship to continue;
3. are jointly responsible for "basic living expenses," as defined below;
4. are not legally married to any other individual;
5. are both eighteen (18) years of age or older;
6. are not related by blood closer than would bar legal marriage;
7. were mentally competent to consent to contract when the domestic partnership began; and
8. is each other's sole domestic partner and are responsible for each other's common welfare.

"Basic living expenses" means the cost of basic food, shelter, and any other expenses of a domestic partner which are paid at least in part by both partners. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

Section II Domestic Status Change Information: Effective Date: _____

In the event of a qualifying change in domestic status, you must complete this form within thirty (30) days of the event, to elect changes in your healthcare and flexible benefit account(s).

Please provide a brief description of the qualifying change in domestic status and attach copies of pertinent documentation.

I understand that this affidavit shall be terminated upon marriage, divorce, legal separation, the death of my spouse/domestic partner or by a change of circumstance attested to in this affidavit.

I agree to notify my payroll/human resources representative if there is any change of status attested to in this affidavit within thirty (30) days of change by filing a new Affidavit of Domestic Status form. Failure to do so could affect eligibility for benefit coverage.

Employee Signature: _____ Date: _____

Human Resources Verification _____ Date: _____

Campus Plan Number: 30141-_____