CITY OF ALBANY

(THIS FORM IS FOR NONBARGAINING, AFSCME UNION, AND FIRE UNION EMPLOYEES ONLY)

AFFIDAVIT OF DOMESTIC PARTNERSHIP

SECTION ONE **AFFIRMATION OF DOMESTIC PARTNERSHIP**

We, undersigned, declare that we are domestic partners, and that we:

1. are each eighteen (18) years of age or older;

2. share a close personal relationship and are responsible for each other's common welfare;

3. are each other's sole domestic partner;

4. are not legally married to anyone nor have had another domestic partner within the previous six months;

5. are not related by blood closer than would bar marriage in the state of Oregon and any other state where we have a permanent residence and are domiciled.

6. have jointly shared the same regular and permanent residence for at least six (6) months immediately preceding the date of this Affidavit with the intent to continue doing so indefinitely;

7. are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. ***You must provide by attaching copies of at least three of the following as verification of your joint responsibility (information should be dated to confirm eligibility at time of enrollment):***

   (a) Joint mortgage or lease.
   (b) Designation of the domestic partner as primary beneficiary for a life insurance or a retirement contract.
   (c) Designation of the domestic partner as primary beneficiary in the employee/covered member's will.
   (d) Durable power of attorney for health care or financial management.
   (e) Joint ownership of a motor vehicle, a joint checking account, or a joint credit account.
   (f) A relationship or cohabitation contract which obligates each of the parties to provide support for the other party.

8. were mentally competent to consent to contract when your domestic partnership began and remain mentally competent.

SECTION TWO **DECLARATION OF MEMBER**

1. I understand that my domestic partner is eligible for enrollment at:
   (a) the time of my hire;
   (b) during an open enrollment period;
   (c) or within 31 days of meeting the criteria listed in Section One.

2. I understand that children of my domestic partner are eligible if they meet the requirements for an eligible dependent as defined by the City's health insurance plans.

3. In the event of my death, my covered domestic partner and any dependent children of my domestic partner may elect survivor coverage or COBRA continuation coverage on a self-pay basis. Survivor coverage will end when my former domestic partner establishes another domestic relationship or for other nonqualifying events. Dependent children coverage will end when they no longer meet the City's health plans' eligibility requirements or are adopted by a new parent.

4. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change in circumstance attested to in this Affidavit. Dependent children coverage will end when they no longer meet the City's health plans' eligibility requirements or are adopted by a new parent.

5. I agree to file a Statement of Termination of Domestic Partnership with a representative of City Manager/Human Resources or Payroll within 30 days of any change to circumstances attested to in this Affidavit.

6. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed with my City/Manager/Human Resources or Payroll representative until such time as the conditions in Section One above have been met.

SECTION THREE **DECLARATION OF PARTNERS**

1. We understand that the information contained in the Affidavit will be held restricted and relates to eligibility for benefits under a group medical or dental plan. Any other use of this information will be subject to disclosure only upon either of our written authorization or as required by law.

2. We understand that a civil action may be brought against us individually and jointly for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit of Domestic Partnership and that such willful falsification of information may result in the termination of our enrollment of the City's health insurance plans and/or termination of employment with the City.

3. We understand that in addition to the eligibility requirements of the City's health plans for domestic partner coverage, there are terms and conditions of coverage set forth in the Service Agreement of each health care plan offered through the City's health plans to which we agree to be bound.

4. We understand willful falsification of information contained in this Affidavit will result in termination of enrollment pursuant to this agreement by the City's health plans and/or termination of employment.

TAX REPORTING FOR DOMESTIC PARTNERS
5. We understand that under applicable federal and state income tax law, payments of health coverage of a domestic partner may not be eligible for pretax treatment. In addition, coverage of the domestic partner may result in additional imputed taxable income to the employee and related withholding for payroll taxes (including income and social security taxes) by the City. The imputed income feature does not apply if you are eligible to claim your domestic partner and/or their children as dependents for tax purposes. ***Check the following box(es)*** if you will be claiming your domestic partner ☐ or their children ☐ for tax purposes. If you need assistance in determining your domestic partner's eligibility or their children's eligibility as a tax dependent, please contact your tax advisor. ***If neither of the above applies, please initial here.*** ☐

We certify under penalty of perjury under the laws of the state of Oregon and Washington that the foregoing is true and accurate to the best of our knowledge.

_____	_____
Signature of City Employee	Signature of Domestic Partner
_____	_____
Print Name	Print Name
_____	_____
Date	Date