County of Santa Clara

Employee Services Agency
Department of Human Resources

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AFFIDAVIT OF DOMESTIC PARTNERSHIP For Health or Dental Plan Enrollment Of Same-Sex Domestic Partners & Domestic Partner's Children

I,_____ SSN:_____
(Name of Employee - Please Print) (Employee's SSN)

☐ A. I, and _____ SSN:_____
(Name of Domestic Partner - Please Print) (Domestic Partner's SSN)

are, and have been domestic partners since _____, and I wish to enroll my domestic partner in my health and/or dental plan. (Date of Domestic Partnership)

We attest to the following:

1. Are of the same sex, and
2. Share the same regular and permanent resident, and
3. Have a close personal relationship, and
4. Are jointly responsible for "basic living expenses", as defined below, and
5. Are not married to anyone else, and
6. Are each eighteen (18) years of age or older, and
7. Are not related by blood closer than would bar marriage, and
8. Were mentally competent to consent to contract when our domestic partnership began, and
9. Are 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 other necessities of life. 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.

SEE PAGE TWO FOR ADDITIONAL INFORMATION

☐ B. I am enrolling my same-sex domestic partner's children in my health or dental plan coverage. **(Complete pages two and three)**

NOTIFICATION OF TAXATION OF HEALTH PLAN PREMIUM PAYMENT FOR ENROLLMENT OF A DOMESTIC PARTNER & YOUR PARTNER'S CHILDREN

The Internal Revenue Service has determined that a portion of the biweekly premium of health insurance coverage **paid by the County of Santa Clara** for family coverage will be reported as taxable income for the employee if a same-sex domestic partner and the same-sex domestic partner's children are enrolled on the individual employee's health plan.

Only the portion of the family health plan biweekly premium **paid by the County** is considered taxable income to the employee. If you are a part-time employee paying for a portion of your health plan coverage or if you are an employee with a biweekly family premium deducted from your paycheck, the portion you are paying is not considered taxable income. This taxation does not apply to your dental plan coverage.

The amount of taxable income will appear on your paycheck stub as "other earnings" and may vary for each employee depending on the health plan coverage and the number of other eligible individuals currently enrolled on your health plan.

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

I agree to notify my Human Resource representative if there is any change of circumstances to this affidavit within 30 days of change by completing and filing any required paperwork.

After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed until 90 days after such required paperwork has been completed and filed with my Human Resources representative, unless such termination is due to the death of my domestic partner.

We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or if otherwise required by law.

We understand that this declaration of responsibility for our common welfare may have legal implications and **will have tax consequences**.

We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, because of a false statement contained in this Affidavit.

We have read and understand all of the above and certify under penalty of perjury that the foregoing is true and correct.

_____	_____
Signature of Employee	Signature of Domestic Partner
_____	_____
Employee's Work Telephone Number	Date Signed by Employee & Domestic Partner

DECLARATION OF STATUS OF SAME-SEX DOMESTIC PARTNER'S DEPENDENT CHILDREN

I wish to enroll the following dependent children in my health or dental plan coverage:

	Child's Name	Child's SSN	Relationship to Employee
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

I agree to notify my Human Resource representative should any of the above-named dependent children become ineligible for coverage under current plan provisions. See your health and dental plan brochures for the definition of an eligible dependent.

_____ _____

Signature of Employee Date Signed by Employee

_____ _____

Employee's Work Telephone Number Employee's Home Telephone Number

Revised 04/97