Risk Management JPA
Fringe Benefits Consortium
SAN DIEGO COUNTY AND IMPERIAL COUNTY SCHOOLS

DOMESTIC PARTNERS – ELIGIBILITY AND ENROLLMENT

District Name: _____

AFFIDAVIT OF DOMESTIC PARTNERSHIP

Section One

We declare that:

1. We have a committed relationship of mutual caring and have been living together in the same household for at least six months prior to the effective date of our coverage under the health/dental/vision or psychological plan specified on the attached enrollment paper and offered through the San Diego County Schools Fringe Benefits Consortium.*
2. Our relationship is expected to be long term.
3. We are both 18 years of age or older.
4. Neither of us is married or has another domestic partner.
5. We are and have been responsible to each other for the direction and management of our household for at least six months prior to the effective date of our coverage under the health/dental/vision or psychological plan specified by the attached enrollment paperwork.*
6. We are financially responsible to third parties for each other.
7. At least six months have elapsed since a previous domestic partnership ended.
8. Neither of us is a blood relative of the other.

Section Two

1. I agree to provide written notice to my Benefits Department if there is a change of circumstances attested to in this Affidavit within 30 days of the change by filing a Statement of Termination of Domestic Partnership.

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Section Two - continued

2. We understand that civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of a willful falsification of information contained in this Affidavit of Domestic Partnership.

3. We understand that under applicable federal and state income tax law, payments for health coverage of a domestic partner may result in additional imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes). Consult with your District's Benefits/Payroll Department for information.

4. We understand willful falsification of information contained in this Affidavit may result in our termination of enrollment by the health care plan that we select for coverage.

5. We also certify under penalty of perjury under the laws of the State of California, that the foregoing is true and accurate to the best of our knowledge.

_____ _____

Employee's Signature Domestic Partner's Signature

_____ _____

Print Employee's Name Print Domestic Partner's Name

_____

Date

***APPROPRIATE DOCUMENTATION MUST BE ATTACHED**