Affidavit for Domestic Partnership and Domestic Partner's Dependents

This affidavit must be completed if you are adding coverage for a Domestic Partner or Dependent Child of a Domestic Partner

Domestic Partnership:

I, _____ and _____,
(Employee) (Domestic Partner)

certify that we are Domestic Partners and that we:

(1) Are each at least 18 years old;
(2) Are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
(3) Are not married, in a civil union, or in a domestic partnership with another individual;
(4) Have been in a committed relationship of mutual interdependence for at least **12 consecutive months** in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely;

Financial Interdependence is established by providing one of the following dated documents:

(a) Joint ownership or lease of a motor vehicle
(b) Joint lease, mortgage or deed of your primary residence
(c) Joint checking, savings, investment or credit account
(d) Designation as the primary beneficiary for life insurance, retirement benefits or the domestic partner's will

(5) Share our common primary residence.

Common Primary Residence is established by providing one of the following documents:

(a) Joint lease, mortgage or deed of your primary residence
(b) Copies of individuals' driver's license, state-issued identification card or voter's registration card listing common primary address
(c) Utility or other household bill with both the name of the insured and the domestic partner appearing

Tax Affidavit for Domestic Partner

In some cases, your Domestic Partner may qualify as an eligible tax dependent. If he/she meets **all** three criteria below, the coverage attributable to your domestic partner may be eligible for tax-favored treatment. Please **initial** each description that applies to your Domestic Partner only if all three apply **AND** include a copy of your most recent income tax filing (with salary information blacked out).

Initials	Tax Dependent Criteria:
	The Dependent is a person who is not my lawful spouse who lives with me and is a member of my household for the entire year.
	I provide over half of the Dependent's support for the calendar year(s) in which coverage is provided.
	The Dependent is not my or anyone else's qualifying child for the tax year(s) in which coverage is provided.

We solemnly affirm under the penalties of perjury under applicable state laws, that the foregoing is true and accurate. We understand that willful falsification of information contained in this Affidavit can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the domestic partner, and the termination of coverage for the employee/retiree. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees, because of a false statement contained in this affidavit. In addition, where permissible, employment related action may be taken against an active employee.

We agree to promptly notify Allentown School District upon any changes or circumstances attested to in this affidavit. We understand that we may not file another affidavit until at least one (1) year after termination of this domestic partnership.

_____ _____ _____
Signature of Employee Social Security Number Date

_____ _____ _____
Signature of Domestic Partner Social Security Number Date

Dependent Tax Affidavit for Domestic Partner's Dependents:

Name of Employee/Retiree: _____ Social Security Number: _____

Name of Domestic Partner's Dependent: _____

Dependent's Date of Birth: _____Social Security Number: _____

Part A: Dependent Relationship, Marital Status, and Age/Capability Requirements

A. Initial the box for the correct dependent relationship for your domestic partner's dependent listed above. If none apply, this person is NOT eligible to be added to your health benefits coverage.		
Initials	**Dependent Relationship**	**Required Documentation**
	Biological Child of Domestic Partner	- Copy of Child's Official State Birth Certificate
	Adopted Child or child placed with domestic partner for adoption by the Domestic Partner	- Copy of Adoption papers indicating child's date of birth - For pending adoptions – see Benefits Guide
	Step-Child of Domestic Partner	- Copy of Child's Official State Birth Certificate - Copy of domestic partner's Official State Marriage Certificate from previous marriage
	Grandchild of Domestic Partner	- Copy of Child's Official State Birth Certificate - Copy of Child's Parent's Official State Birth Certificate (to show relationship to domestic partner)
	Legal Ward of Domestic Partner (permanently resides with my domestic partner and my domestic partner is his/her testamentary or court appointed guardian for a non-temporary guardianship of not less than 12 months.)	- Copy of Child's Official State Birth Certificate - Proof of Residency (Valid Driver's License, or State-issued Identification Card, school records or day care records certifying dependent's address, Tax Documents listing child's name certifying address.) - Copy of Legal Ward/Testamentary Court Document, signed by a Judge.
	Other Child Relative (includes step-grandchildren) of Domestic Partner - dependent is related to my domestic partner by blood, permanently resides with my domestic partner, and my domestic partner provides his/her sole support.	- Copy of Child's Official State Birth Certificate - Proof of Residency (Valid Driver's License, or State-issued Identification Card, school records or day care records certifying dependent's address, Tax Documents listing child's name certifying address.) - Signature of Sole Support Affirmation (see below)
B. Initial the box by the statement that describes the Dependent. If neither statement accurately describes this Dependent, this person is not eligible for State employee/retiree health benefits coverage.		
	The Dependent is under the age of 26.	
	The Dependent is any age and is incapable of self-support because of a mental or physical incapability incurred before reaching age 26 and is chiefly dependent on me and/or my domestic partner for support.	

Sole Support Affirmation for Other Child Relative Dependent ONLY:

I certify by my signature below that the dependent child listed on this form is supported solely by me and/or my domestic partner.

_____ _____

Domestic Partner's Signature Date

Part B: Tax Criteria

In some cases, the dependent of your Domestic Partner may qualify as your eligible tax dependent. If he/she meets **all four** criteria for the Qualifying Child Test or **all three** criteria for the Qualifying Relative Test shown below, the coverage attributable to your domestic partner's dependent may be eligible for tax-favored treatment. **If you cannot initial all four Qualifying Child or all three Qualifying Relative criteria, this person is NOT an eligible tax dependent and the portion of your coverage attributable to this dependent is not eligible for tax-favored status.**

Initials	Qualifying Child Test Criteria – must meet all four criteria
	The child is my biological child or adopted child (or placed for adoption by me), my legal ward or child placed with me under court order (not temporary for less than 12 months), sibling, or descendent of my child or sibling (i.e. grandchild, niece, nephew, etc); **and**
	The child lives with me for more than half of the year (more than six months) or is my biological or adopted child and meets the following residence exceptions: -The child received over half of the child's support during the calendar year from the child's parents, who **(1)** are divorced or legally separated under a decree of divorce or separate maintenance, **or (2)** are separated under a written separation agreement, **or (3)** live apart at all times during the last six months of the calendar year; **and** -The child is in the custody of one or both of the child's parents for more than half of the calendar year; **and** -
	The Child has not attained age 26 **or** is permanently and totally disabled; **and**
	The child has not provided more than half of the child's own support for the calendar year(s) in which coverage is provided.

~OR~

Initials	Qualifying Relative Test Criteria – must meet all three criteria
	The Dependent has a specified relationship to me: my biological child, my adopted child (or placed for adoption by me), my step-child, my grandchild, my niece, my nephew, my sibling, or a person who is not my lawful spouse who lives with me and is a member of my household for the entire year (this includes a legal ward); **and**
	I provide over half of the Dependent's support for the calendar year(s) in which coverage is provided; **and**
	The Dependent is not my or anyone else's qualifying child for the tax year(s) in which coverage is provided. If this child meets criteria for the Qualifying Child Test, this statement is not true.

We solemnly affirm under the penalties of perjury under applicable state laws, that the foregoing is true and accurate. We understand that willful falsification of information contained in this Affidavit will result in our termination of enrollment. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees, because of a false statement contained in this affidavit.

_____ _____

Signature of Employee Date

_____ _____

Signature of Domestic Partner Date

Notary Acknowledgement

State of _____

County of _____

On_____, before me, _____,
(date) (notary)

personally appeared, _____,
(signers)

Who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal

_____

(notary signature)

My Commission Expires: _____

(seal)