



Affidavit of Domestic Partnership

1. Domestic Partners

This form is only required for domestic partnerships not documented in a state registry. If your domestic partnership is registered in a state registry, you are eligible to enroll on the medical plan without completion of this form.

A. I, _____ certify that I, and _____
Print Name of Employee Print Name of Domestic Partner

are domestic partners, and we:

1. currently share the same regular and permanent residence, and
2. have a close personal relationship, and
3. are jointly responsible for "basic living expenses" as defined below, and
4. are not married to anyone, and
5. are each eighteen (18) years of age or older, and
6. are not related by blood closer than would bar marriage in Washington state, and
7. were mentally competent to consent to contract when our domestic partnership began, and
8. are each other's sole domestic partner and are responsible for each other's common welfare.

B. "Basic living expenses" means the cost of basic food, shelter, and any other expenses of a domestic partner. 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.

2. Employee

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

B. I agree to notify the Business Office if there is any change in circumstances attested to in this Affidavit within thirty (30) days of the change.

C. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed within _____ as determined by the Group, but in no case less than 90 days, after a request for termination of domestic partnership has been filed with the Business Office. (This provision does not apply to state-registered domestic partners.)

3. Agreement

A. We understand that this information will be held confidential and will be subject to disclosure only to WCIF for purposes of confirming our eligibility or upon our written authorization or as required by law.

B. We understand that this declaration of responsibility for our common welfare may have legal implications under Washington law.

C. 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 of Domestic Partnership.

D. We also certify under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

E. I, the undersigned Employee, understand that will falsification of information on this Affidavit may lead to disciplinary action , up to and including discharge from employment.

Note: IT is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance coverage.

Signature of Employee

Signature of Domestic Partner

_____/_____/_____
Date Signed (MM/DD/YYYY)

_____/_____/_____
Date Signed (MM/DD/YYYY)

Note to Group: Keep original for your file and only submit a copy of the updated enrollment application to WCIF.