AFFIDAVIT OF DOMESTIC PARTNERSHIP

Please complete this affidavit completely and have it notarized prior to submitting to HR Benefits. All NEW domestic partnerships must include the full date of your domestic partnership to support your qualifying family life event.

I, ___________________________, Employee ID ________________, certify that: _________________________________

(Print Name) (Print Name)

and I are domestic partners and have been since: _________ /_________ /_________ and we:

(MM/DD/YYYY)

1. Share the same permanent residence, AND
2. Have a close personal relationship, AND
3. Are jointly responsible for basic living expenses, AND
4. Are single or divorced, AND
5. Are 18-years of age or older, AND
6. Are not related by blood, AND
7. Are each other's sole domestic partner and are responsible for each other's common welfare.

Please initial each section acknowledging your domestic partnership eligibility:

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

B. I agree to notify my benefits/personnel representative if there is any change of circumstances attested to in this affidavit within thirty-one (31) days of the change by filing a Statement of Termination of Domestic Partnership.

C. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed until ninety (90) days after the submittal of a Statement of Termination of Domestic Partnership, unless such termination is due to the death of my domestic partner.

D. I understand that this affidavit expires at the end of each plan year and that I must sign a new affidavit during the Annual Enrollment period each year to:

   a. Be eligible to use sick time, FMLA leave, or bereavement leave for my domestic partner and/or my domestic partner's dependent(s).

   b. Continue insurance coverages for my domestic partner and/or my domestic partner's dependent(s).

E. I understand that under **IRS Publication 969**, a domestic partner is not considered a spouse for federal tax purposes; therefore, the coverage is taxed accordingly.

Employee Signature: ____ EIN: _______________ Date: ________________

State of Arizona, County of ________________________________ Subscribed and sworn (affirmed) before

me on this _______________________ day of ______________________, 20 ________.

My Commission expires: ___________________ Notary Public __________________________ [SEAL]