# PEBB Affidavit of Domestic Partnership Instructions www.oregon.gov/DAS/PEBB

Complete and notarize this form to add a Domestic Partner, domestic partner and partner's children or domestic partner's children only **without** a Certificate of Registered Domestic Partnership. For detailed information on eligibility of a domestic partner's children refer to the PEBB Benefits Handbook or web site.

• The notarized affidavit must be on file **within 5 business days** of submission of this enrollment election If not, coverage for the domestic partner and eligible domestic partner's dependents will terminate retroactive to the effective date.

Employees must pay a tax on the imputed value for medical and dental coverage for a domestic partner and/or domestic partners' children.

The taxable amount will show on the first paycheck you receive after the addition of a domestic partner, domestic partner's children or both. You have two weeks following receipt of that first paycheck reflecting this amount to cancel enrollment retroactive to the date the change in enrollment became effective.

#### **SECTION A**

• Complete each item in this section

## **SECTION B**

Complete each item in this section for domestic partner.

## **SECTION C**

Read this entire section carefully.

# **SECTION D**

• Complete this section for domestic partner's eligible children.

## **SECTION E**

- Read this entire section carefully. Notarize, sign and date.
- Make a copy for your records and submit to your agency/university payroll or benefits office.
- If you are a Self-Pay Participant or COBRA submit your forms to BenefitHelp Solutions (BHS), PO Box 67240, Portland, OR 97268-1240.
- Sending your forms to the wrong address will delay your change.



# AFFIDAVIT OF DOMESTIC PARTNERSHIP FORM

SECTION A - SUBSCRIBER INFORMATION						
LAST NAME	FIRST NAME	MI	ID NUMBER (SSN, OUS#, BENEFIT #)			
DATE OF BIRTH (MM-DD-YYYY)						
DATE OF BIRTH (MINI-DD-1111)		GENDER	☐ FEMALE ☐ MALE			
RESIDENCE ADDRESS	□ New Address	CITY	STATE ZIP			
		COUNTY	HOME PHONE			
MAILING ADDRESS (if different from above)	□ New Address	AGENCY	WORK PHONE			
E-MAIL ADDRESS						
L-IMAIL ADDRESS						
SECTION B - DOMESTIC PARTNER INFORMATION						
LAST NAME	FIRST NAME	МІ	ID NUMBER (SSN, OUS#, BENEFIT #)			
E/OT WILE	THOTAVINE	'*''	IB NOMBER (CON, COOM, BENEFIT II)			
DATE OF BIRTH (MM-DD-YYY)	DATE CRITERIA MET					
SECTION C. DECLARATION OF D	OMESTIC DARTNERSHIP					

We declare that we are domestic partners, and we meet all of the following criteria:

- Are both at least eighteen (18) years of age and mentally competent to consent to this contract.
- Are responsible for each other's welfare and are each other's sole domestic partners;
- Are not married to anyone;
- Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
- Currently share the same regular permanent residence; and
- Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.
- Are able to provide at least three of the following as verification of our joint responsibility.
  - o Joint mortgage or lease,
  - o Designation of each other as primary beneficiary for life insurance or retirement contract,
  - o Durable power of attorney for health care or financial management,
  - o Joint ownership of a motor vehicle,
  - o Record of a joint checking account,
  - o Record of a joint credit account, or
  - o A relationship or cohabitation contract that obligates each of us to provide support for the other.

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# SECTION D - CERTIFICATION OF DOMESTIC PARTNER'S DEPENDENT CHILDREN

Last Name	First	MI	Birth Date	
Last Name	First	MI	Birth Date	
Last Name	First	MI	Birth Date	
SECTION E - ACKNO	WLEDGEMENTS - E	MPLOYEE & DOME	ESTIC PARTNER AUTH	ORIZATION & SIGNATURE
and the admin		nefits. Any other u	se of this information v	nining our eligibility for benefits will be subject to disclosure only
			es, including reasonab d in this Affidavit of Do	le attorney fees and court costs, omestic Partnership.
Availability of t program provis		ed on eligibility red	quirements and subjec	t to any future changes in PEBB
personnel, pay criteria atteste	roll, benefits office of to in this declaration	or BHS within 60 d on. The eligibility fo	ays of when the partne	rtnership" form notifying ership no longer meets all of the omestic partner's children) end the nts.
	ation of a domestic parter and domestic par			nination of benefits for the
	company shall be e ineligible individuals		rom the PEBB subscri	ber any expenses for claims
knowledge.  • We have read		eligibility requirem		rue and accurate to the best of our
Employee Signature: _		Domesti	c Partner:	Date:

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Sworn and Subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Signature of Notary Public\_\_\_\_\_\_ Official Title: \_\_\_\_\_