

Employee's Name: _____ SSN: _____

GTFF HEALTH PLAN
AFFIDAVIT OF DOMESTIC PARTNERSHIP

SECTION ONE

I and _____ are domestic partners and we:
(Name of Domestic Partner)

- 1) Are each eighteen (18) years of age or older;
- 2) Share a close personal relationship and are responsible for each other's common welfare;
- 3) Are each other's sole domestic partner;
- 4) Are not married to anyone nor have had another domestic partner within the prior 31 days;
- 5) Are not related by blood closer than would bar marriage in the states of Oregon or Washington;
- 6) Share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
- 7) Are jointly financially responsible for "basic living expenses", defined as the cost of basic food, shelter, and any other expenses of a domestic partner which are paid at least in part by a program or benefit for which the partner qualified because of the domestic partnership. (Note: Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost);
- 8) Were mentally competent to consent to contract when our domestic partnership began.

SECTION TWO

- 1) I understand that my domestic partner is eligible for enrollment on the same terms as other dependents covered under the plan.
- 2) I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in circumstance attested to in this Affidavit.
- 3) I agree to provide written notice to the GTFF if there is any change of circumstances attested to in this Affidavit within 30 days of the change by filing a Statement of termination of Domestic partnership.
- 4) After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed until thirty one (31) days after the filing of a Statement of Termination.

