AFFIDAVIT FOR ENROLLMENT OF DOMESTIC PARTNERS

I. DECLARATION OF DOMESTIC PARTNERSHIP

I, _____ and I, _____

declare under penalty of perjury that we are domestic partners within the meaning of the following declaration:

A. We are each eighteen (18) years of age or older.

B. We share a close personal relationship and are responsible for each other's common welfare.

C. We are each other's sole domestic partner.

D. We are not married to anyone nor have had another domestic partner within the prior six months.

E. We are not related by blood closer than that which would bar marriage in the State of California.

F. We share the same regular and permanent residence, with the current intent to continue doing so indefinitely.

G. We are **mutually** financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and any other expenses of a domestic partner.

H. We were mentally competent to consent to the contract when our domestic partnership began.

I. We will provide documentation requested by the County verifying the above criteria.

II. ENROLLMENT

A. We understand that my domestic partner is eligible for enrollment at the time of my hire, during the official open enrollment period and during the year based on the same eligibility criteria used for other dependents.

B. We understand that dependent children of my domestic partner are eligible for coverage when they are:

- Under the age of 26 for the County medical, dental and vision plans
- Under the age of 26 for the County family AD&D insurance

C. We understand the following with respect to Health Savings Accounts (HSAs):

- We are still considered independent individuals for HSA eligibility and contribution limits. If we are both eligible to contribute to HSAs, due to enrollment in qualifying high deductible health care plans, we will each have a separate HSA contribution limit. The contribution limit will be based on the number of dependents (if any) enrolled under each partner's qualifying high deductible health care plan.

- Our domestic partner status does not prohibit the domestic partner who is not covered by a qualifying high deductible health care plan from contributing to a general purpose Health Care Flexible Spending Account (FSA).
- Our domestic partnership does not automatically qualify us for tax-free or penalty-free disbursements from the other partner's HSA. Disbursements are subject to IRS regulations, and the IRS's definition of dependent.

D. We agree to provide written notification to the Department of Human Resources, Employee Benefits Division if there is any change of circumstances attested to in this Affidavit within 60 days of the change by filing a Statement of Termination of Domestic Partnership.

III. ACKNOWLEDGEMENTS

A. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of falsification of information contained in this Affidavit of Domestic Partnership.

B. We understand that under applicable federal and state income tax law, payments for health, dental and vision coverage for a domestic partner by an employer may result in additional imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes).

C. We understand that in addition to the eligibility requirements of the County of San Diego for domestic partner coverage, there are terms and conditions of coverage set forth in the Group Agreement of each health, dental and vision plan offered by the County of San Diego to which we agree to be bound.

D. We understand that should this partnership terminate, the domestic partner will not be eligible for Cobra benefits.

E. We understand falsification of information contained in this Affidavit may result in our termination of enrollment by the health, dental and vision plans that we select for coverage.

We certify that under penalty of perjury under the laws of the State of California, that the foregoing is true and correct to the best of our knowledge.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Employee ID No.
_____	_____	_____
Printed Name of Domestic Partner	Signature of Domestic Partner	Date of Birth

_____
Date of Completion

Please indicate your requested effective date of coverage:

☐ New Hire

☐ Qualifying Life Event – 1st of the month after submission of Affidavit

☐ Open Enrollment – January 1st

This form must be completed and returned to Human Resources - Benefits Division, *prior* to enrollment of your Domestic Partner. Please return by fax to 858-467-9708 or e-mail DHRBenefits.FGG@sdcounty.ca.gov Please retain a copy for your records.