

AFFIDAVIT OF DOMESTIC PARTNERSHIP

We,		and		_ (domestic partners),			
after b	peing first duly sworn depose and attest to the	ne following:					
•	We are at least 18 years of age and we are	We are at least 18 years of age and we are mentally competent to contract.					
•	Neither of us is legally married to or sepa	Neither of us is legally married to or separated from another person.					
•	We are sole domestic partners, we have been sole domestic partners since (month/day/year nd we intend to remain sole partners.						
•	We have been legally domiciled together for at least [12] months.						
•	We are not related by blood to a degree of closeness that would prohibit marriage in the State of Maine.						
•	Neither of us has covered another individual or has been covered by another individual as a domestic partner or a legal spouse in a [health] or [dental] or [vision] insurance policy in the preceding [12] months. We understand that domestic partners cannot enroll together for [12] months following the termination of coverage of a prior domestic partner or legal spouse.						
•	We are jointly responsible for each other's common welfare as evidenced through a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, and/or powers of attorney authorizing each of us to act on behalf of the other. Maine Municipal Employees Health Trust reserves the right to request, at a future time, one of the previously mentioned documents.						
•	We understand that a domestic partner enrolled as a dependent ceases to be an eligible member on the first of the month following the termination of a domestic partnership and that we are required to submit an Application of Change within 31 days of the termination of a domestic partnership.						
Date	Subscriber Signa	ture	Print Name				
Date	Domestic Partner	r Signature	Print Name				
STAT	E OF		• • • • • • •	, ss			
On thi	is day of	, 20	, personally appeared t	he above named			
	and		, and swore to the truth of t	the foregoing. Before			
me,							
Notar	y Public/Attorney at Law	My Commissio	n Expires:				

We understand that domestic partners are subject to the other eligibility provisions of the Health Trust benefit plans.

We agree to notify the Maine Municipal Employees Health Trust and the employee's employer within thirty (30) days of the termination of our domestic partnership. A written termination statement shall be provided and shall affirm that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner.

We certify, under penalty of perjury, that the foregoing is true and correct. We, the undersigned employee and the Domestic Partner, understand that falsification of information contained in this Affidavit may cause immediate termination of Health Trust health and/or dental plan coverage, and may subject us to civil action to recover any losses, including reasonable attorney's fees incurred by the Maine Municipal Employees Health Trust for benefits provided under its health and/or dental plans. We also understand that falsification of information contained in this Affidavit may lead to disciplinary action, up to and including immediate termination of the employee's employment.

		Date Date	
gnature of Domestic Partner			
Dependent Child Certification			
I,	certify that my Partner's child(ren)	named below meet the following requirem	
	a-appointed legal relationship with the ent, or legal guardian of the child(ren).	child(ren) (i.e., adoption, guardianship), a	
Partner's Dependent Child(r	ren)		
Last Name	First Name	M.I.	
Last Name	First Name	M.I.	
Last Name	First Name	M.I.	
Last Name	First Name	M.I.	
	sibility requirements may cause imme	ediate termination of Health Trust when a deposition of Health Trust health	
dental plan coverage, and may incurred by the Maine Municipal above under its health and/or defailure to inform my employer	l Employees Health Trust for benefits pental plans. I also understand that fals	paid on behalf of the dependent child(ren) is sely certifying as to a dependent's eligibity applicable eligibility requirements may res	
dental plan coverage, and may incurred by the Maine Municipal above under its health and/or defailure to inform my employer	l Employees Health Trust for benefits pental plans. I also understand that falso when a dependent no longer meets a	paid on behalf of the dependent child(ren) is sely certifying as to a dependent's eligibity applicable eligibility requirements may res	
dental plan coverage, and may incurred by the Maine Municipal above under its health and/or defailure to inform my employer disciplinary action, up to and income	l Employees Health Trust for benefits pental plans. I also understand that falso when a dependent no longer meets a cluding immediate termination of employees Health Trust	paid on behalf of the dependent child(ren) is sely certifying as to a dependent's eligibity requirements may really loyment.	

The following section is for certification to an employer of the legal tax dependent status of a domestic partner.

B. Partner Certification as a Tax-Qualified Dependent

is my depen	on consultation with a tax advisor, I certify that the previously named legal tax dependent as defined in the IRS Code Section 152. I understandency status may result in disciplinary action, up to and including immediately certification. I agree to notify my employer immediately	nd that falsification of this certification of ediate termination of employment, as well
By:	G'	
	Signature of Employee	Date