



PEBB Affidavit of Domestic Partnership

- Office Use Only -
Approved by ____ Date ____
Effective Date _____

To add a domestic partner to coverage by affidavit, you must submit this affidavit within five business days of the enrollment. Otherwise, coverage for the individual will be terminated back to the effective date. Do not submit this form if you have a Domestic Partnership through a Registered Certificate.

See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml

Submit completed affidavit to your agency payroll or university benefits office

1. Contact Information

PEBB Benefit Number (P#####), Employee ID, University ID

Last Name	First Name	MI	Agency #	Gender <input type="checkbox"/> F <input type="checkbox"/> M	
PEBB and the plans in which you enroll will send all benefit-related correspondence to your contact address.					
Contact Address	Apt #	City	State	Zip	County
Residence Zip Code	Work Zip Code	Work E-mail		Personal E-mail	(optional)
Date of Birth _ _ / _ _ / _ _ _ _		Work Phone () -		Home Phone	(optional) () -

2. Domestic Partner Information

Last Name	First Name	MI
Date of Eligibility for Coverage _ _ / _ _ / _ _ _ _	Date of Birth _ _ / _ _ / _ _ _ _	

3. Certification of Domestic Partner's Dependent Children

I certify that my domestic partner's children listed below meet PEBB requirements on eligible dependents.

Last Name	First Name	MI	Birth Date (mm/dd/yyyy)	Gender	
				M	F
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Dependent Certification ages 19 up to 24

I certify that dependents age 19 up to 24 listed here are eligible for coverage under PEBB rules.

4. Declaration of Domestic Partnership and Employee Signature

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.
 - Joint mortgage or lease, Designation of each other as primary beneficiary for life insurance or retirement contract, Durable power of attorney for health care or financial management, Joint ownership of a motor vehicle, Record of a joint checking account, Record of a joint credit account, or A relationship or cohabitation contract that obligates each of us to provide support for the other.

We understand that:

- Information provided in this affidavit is to be used for the purpose of determining our eligibility for benefits and the administration of these benefits.
- A civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit.
- Availability of these benefits is based on eligibility requirements and subject to any future changes in PEBB program provisions
- The employee is responsible for submitting a *Termination of Domestic Partnership* form to their agency benefits office within 60 days of when the partnership no longer meets all of the criteria attested to in this declaration. Coverage ends the last day of the month in which the individual(s) become ineligible.

A false declaration of a domestic partnership will result in a retroactive termination of benefits for the domestic partner and domestic partner's eligible children in all plans. The insurance company shall be entitled to recover from the PEBB subscriber any claim amounts processed and paid for ineligible individuals.

We certify that:

Under penalty of perjury under State of Oregon laws that the foregoing is true and accurate to the best of our knowledge.

We have read and understand the eligibility requirements, employee responsibilities, and tax information described in the PEBB Benefit Materials.

Employee Signature

Date

Domestic Partner Signature

Date

State of _____, County of _____

Sworn and Subscribed before me this _____ day of _____ 20_____

**Signature of
Notary Public:** _____

Official Title: _____

Submit completed affidavit to your agency payroll or university benefits office. Keep a copy for your records.