



# PEBB Affidavit of Domestic Partnership

- Office Use Only -

Approved by \_\_\_ Date \_\_\_

Effective Date

**Do not submit this form if you have a Domestic Partnership through an Oregon Registered Certificate.** Use this affidavit to affirm eligibility of a domestic partner. You are responsible for submitting a Termination of Domestic Partnership form to your agency benefits office within 30 days of when the partnership is dissolved. See the Summary Plan Description for more information: [www.oregon.gov/DAS/PEBB/SPD.shtml](http://www.oregon.gov/DAS/PEBB/SPD.shtml)

- **Open Enrollment:** You may enroll your domestic partner through the online system. The partner's enrollment will take effect only if you submit this affidavit to your agency within the allowed time.
- **Newly Eligible Employees, Newly Hired Employees, and Active Employees requesting a midyear change:** You must submit the enrollment form or Midyear Change form and this affidavit to your agency within the allowed time, or the domestic partner will not receive coverage.
- **Submit completed affidavit to your agency payroll or university benefits office.**

|   |   |  |                            |   |     |  |
|---|---|--|----------------------------|---|-----|--|
| <b>1. Contact Information</b><br>You must complete all fields. (Please Print)                                       |   | PEBB Benefit Number (P#####), Employee ID, University ID |                            |   |     |  |
| Last Name   | First Name                                    | MI   | Agency #                   | Gender<br><input type="checkbox"/> F <input type="checkbox"/> M |     |  |
| PEBB and the plans in which you enroll will send <b>all</b> benefit-related correspondence to your contact address. |   |  |                            |   |     |  |
| Contact Address   | <input type="checkbox"/> Check if New Address | Apt #  | City                       | State   | Zip |  |
| Residence Zip   | Work Zip                                      | Work Email   | Personal E-mail (optional) |   |     |  |
| Date of Birth (mm/dd/yyyy)  | Work Phone                                    | Home Phone (optional)                                    |                            |   |     |  |

|  |  |
|--|--|
| <b>2. Domestic Partner Information</b> |  |
| Last Name                              | First Name   |
| Mi                                     |  |
| Date of Birth (mm/dd/yyyy)             | Date Eligibility for domestic Partnership was met (mm/dd/yyyy) |

|  |            |    |                         |                  |
|--|------------|----|-------------------------|------------------|
| <b>2. Certification of Domestic Partner's Dependent Children</b> I certify that my domestic partner's children listed below meet PEBB eligible dependent requirements. |            |    |                         |                  |
| Last Name  | First Name | MI | Birth Date (mm/dd/yyyy) | Gender<br>M    F |
|  |            |    |                         |                  |
|  |            |    |                         |                  |

|  |
|--|
| <b>3. Employee Signature and Authorization</b>   |
| We declare that we are domestic partners, and we meet all of the following criteria on this date:  |
| <ul style="list-style-type: none"> <li>• Are both at least eighteen (18) years of age and mentally competent to consent to this contract;</li> <li>• Are responsible for each other's welfare and are each other's sole domestic partner;</li> </ul> |

- 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, if requested.
  - 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.

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made based on this affidavit are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay.

**I understand that:**

- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines
- Knowingly making a false statement may subject me to termination of enrollment, denial of future enrollment, or civil damages.

I also understand that if I fail to report on required forms a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

This affidavit supersedes all forms and submissions I previously made for PEBB coverage for the individual named on this affidavit. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

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

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**4. Notary Stamp**

State of: \_\_\_\_\_, County of: \_\_\_\_\_

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

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

You must submit a midyear change form to your agency within 30 days of the date when an individual you provide coverage to is no longer PEBB eligible. Individuals will be removed prospectively from coverage the last day of the month in which the agency receives the midyear change form from the employee. The exception to prospective removal from coverage is when an ex spouse, ex domestic partner or any child becomes ineligible for coverage because of divorce or dissolution of partnership. In this exception, the ineligible individuals will be removed from coverage the last day of the month in which the divorce or dissolution occurred. Late submission may affect your income taxes. In the case of retroactive terminations, you may be responsible for claims paid for the individual during the period of ineligibility. If you do not report changes of eligibility that occur before open enrollment, you may face civil or criminal charges for fraud, and PEBB may rescind coverage.

**Submit complete form to your agency payroll or university benefits office.**

**Keep a copy of your benefit forms for your records.**

**Any alteration of this form may result in it being ineffective.**