pebb
Public Employees' Benefit Board

Affidavit of Domestic Partnership

Office use only
Approved by: ________________
Approved date: ________________
Effective date: ________________

Use this affidavit to affirm eligibility of a domestic partner. See the Summary Plan Description for more information: www.pebbinfo.com.

- **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/university benefit office or the domestic partner will not receive coverage.
- **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/university benefits office during open enrollment or within seven days following the close of open enrollment or the domestic partner will not receive coverage.

Contact information *(You must complete all fields, please print.)*

PEBB benefit number (P########), OR#, University ID or Lottery ID

Last name	First name	Middle	Gender ☐ M ☐ F ☐ Other

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

☐ Check if new address

Contact address	Apartment #	City	State	ZIP

Residence ZIP code	Work ZIP code	Work email	Personal email (optional)

Date of birth (mm/dd/yyyy)	Work phone	Home phone (optional)

Domestic partner information

Last name	First name	Middle

Date of birth (mm/dd/yyyy)	Date Domestic Partnership became eligible (mm/dd/yyyy)

Certification of Domestic Partner's dependent children

(I certify that my Domestic Partner's children listed below meet PEBB eligible dependent requirements.)

Last name	First name	Middle	Birth date (mm/dd/yyyy)	Gender M	Gender F	Gender Other
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Employee signature and authorization

We declare we are domestic partners, and we meet all of the following criteria on this date:

- Are both at least eighteen (18) years of age and mentally competent to consent to this contract;
- Are both responsible for each other's welfare and are each other's sole domestic partner;
- Neither of us are married to anyone;
- Share a close intimate and committed relationship of mutual caring 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 financial information, 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.
- We are not in this relationship solely for the purpose of obtaining benefit coverage.
- We declare that the individuals listed on this affidavit and I are eligible for the coverage requested. I understand the benefit elections made on this application 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.

We understand that:

- A person 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.
- If I fail to report 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.
- You must submit a midyear change form to your benefit office within 30 days of the date when an individual you provide coverage for is no longer PEBB eligible. If your notice is late, you and your qualified beneficiaries may lose the right to elect COBRA.
- This affidavit supersedes all forms and submissions I previously made for PEBB coverage for individuals named on this affidavit.

We certify under penalty of the State of Oregon laws that the foregoing is true and accurate to the best of my knowledge and belief, and I understand they are subject to penalty for false claims.

____ ____________________

Employee signature Date

____ ____________________

Domestic partner signature Date

After being notarized, submit this completed 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.

Notary stamp

State of ______________________________, **County of** ____________________

Sworn and subscribed before me this ____________________ **day of** ____________ **20**________

Signature of Notary Public: ________________________ **Official title:** ______________