



DEPARTMENT OF ADMINISTRATION

Office of Employee Benefits

One Capitol Hill – 3rd Floor

Providence, RI 02908-5890

Phone: (401) 222-3160

Fax: (401) 222-2964

AFFIDAVIT OF DOMESTIC PARTNERSHIP

Employee Name

Domestic Partner Name

1. Evidence and Certification of Domestic Partnership:

In accordance with R.I. Gen. Laws §§36-12-1, et. seq., we hereby certify that as domestic partners, we meet the following criteria:

- A. We are at least eighteen (18) years of age and are mentally competent to contract.
- B. Neither of us is married to anyone else.
- C. We are not related by blood to a degree which would prohibit marriage in Rhode Island.
- D. We reside together and have resided together for at least one (1) year.
- E. We are financially interdependent as evidenced by at least two of the following four items: (Circle two as appropriate. Note that two items from #4 below only count as one of the two required items to prove financial interdependency. If you circle two items from #4 below you must also provide evidence of either #1, #2, or #3 below. Attach appropriate documentation*)
 1. Domestic Partnership Agreement or a Relationship Contract.
 2. Joint mortgage or joint ownership of primary residence.
 3. The domestic partner has been designated as a beneficiary for the employee's will, retirement contract, or life insurance.
 4. At least two of the following items: (circle two)
 - joint ownership of vehicle
 - joint checking account
 - joint credit account
 - joint lease

(*Original document or certified copy of documents submitted as proof must be attached to this affidavit. Original documents will be returned to the employee. The employee may also bring such documentation in person to the Office of Employee Benefits)

2. Termination of Domestic Partnership:

I (employee) agree to notify the Administrator of the Office of Employee Benefits if the status of my domestic partner relationship changes - including termination of the relationship or failure to meet any of the above criteria - no later than thirty-one (31) days from the date of such change.

The Rhode Island State Employee Health Plan complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services, free of charge, are available to you. Call (401) 222-3160.

3. Insurance Coverage under R.I. Gen. Laws §§36-12-1, et. seq.:

We understand that under R.I. Gen. Laws §§36-12-1, et. seq., insurance coverage is available to the following:

- The employee;
- The employee’s spouse;
- The employee’s unmarried children under the age of 19 (or as otherwise permitted by law); and
- The employee’s domestic partner (if pursuant to R.I. Gen. Laws §27-20.4-1, no former spouse is covered) as evidenced and required in No. 1 above.

4. We understand that the information contained in this Affidavit is confidential and is being provided for the sole purpose of determining eligibility for benefits.

5. We affirm that the statements attested to in this Affidavit are true and correct to the best of our knowledge. Misrepresentation of information in the affidavit will result in an obligation to repay the benefits received, and a civil fine not to exceed one thousand dollars (\$1000) enforceable by the attorney general and payable to the general fund.

State of Rhode Island
County of _____

I, _____ do hereby under oath depose and say that the foregoing representations, information and documentation provided herein are true, correct, and complete.

Employee Signature Employee Social Security # Date State Dept./Agency

Subscribed and sworn to before me in _____, Rhode Island on the _____ day of _____ 20____.

Notary Public My Commission Expires:
(Print Name: _____)

State of Rhode Island
County of _____

I, _____ do hereby under oath depose and say that the foregoing representations, information and documentation provided herein are true, correct, and complete.

Domestic Partner Signature Domestic Partner Social Security # Date

Subscribed and sworn to before me in _____, Rhode Island on the _____ day of _____ 20____.

Notary Public My Commission Expires:
(Print Name: _____)

APPROVED/DISAPPROVED: _____ (OEB Administrator) **DATE:** _____

The Rhode Island State Employee Health Plan complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services, free of charge, are available to you. Call (401) 222-3160.