



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

**DEPARTMENT OF ADMINISTRATION**

Office of Employee Benefits

One Capitol Hill – 3<sup>rd</sup> Floor

Providence, RI 02908-5890

Phone: (401) 222-3160

Fax: (401) 222-2964

**AFFIDAVIT OF DOMESTIC PARTNERSHIP**

\_\_\_\_\_  
Employee Name (print or type)

\_\_\_\_\_  
Domestic Partner Name (print or type)

**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:

- We are at least eighteen (18) years of age and are mentally competent to contract.
- Neither of us is married to anyone else.
- We are not related by blood to a degree which would prohibit marriage in Rhode Island.
- We reside together and have resided together for at least one (1) year.
- We are financially interdependent as evidenced by at least two (2) of the following four (4) items: (Check two as appropriate. Attach appropriate documentation.\*)
  - Domestic Partnership Agreement or a Relationship Contract.
  - Joint mortgage or joint ownership of primary residence.
  - As partners, we are financially interdependent as evidenced by at least **two (2)** of the following items: (circle two):
    - joint ownership of vehicle
    - joint checking account
    - joint credit account
    - joint lease
  - The domestic partner has been designated as a beneficiary for the employee's will, retirement contract, or life insurance.

(\*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 in person to the Office of Employee Benefits, located at 1 Capitol Hill in Providence).

**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 (30) days from the date of such change.

**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 this Affidavit will result in the obligation to repay the benefits received, and a civil fine not to exceed one thousand dollars (\$1,000) enforceable by the Rhode Island 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: \_\_\_\_\_)

**Approval:** \_\_\_\_\_  
**(Administrator Signature)**

\_\_\_\_\_  
**Administrator of Office of Employee Benefits (print name)**                      **Date**