



**DEPARTMENT OF ADMINISTRATION**

Office of Employee Benefits

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**DOMESTIC PARTNERSHIP AFFIDAVIT**

\_\_\_\_\_  
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:

- 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. ***(Attach supporting documentation)***
- We are financially interdependent as evidenced by at least two (2) of the following four (4) items. Note that two items from #3 below only count as one of the two required items to prove financial interdependency. If you circle two items from #3 below you must also provide evidence of either #1, #2, or #4 below. (Attach appropriate documentation)
  1. Domestic Partnership Agreement or a Relationship Contract.
  2. Joint mortgage or joint ownership of primary residence.
  3. At least **two (2)** of the following items:
    - joint ownership of vehicle
    - joint checking account
    - joint credit account
    - joint lease
  4. The domestic partner has been designated as a beneficiary for the employee's will, retirement contract, or life insurance.

**2. Acknowledgment of Rules Related to Termination of Domestic Partnership:**

I (employee) understand that if I get married to my domestic partner, it is my responsibility to inform the Office of Employee Benefits immediately. I understand that my failure to do so will prevent me from obtaining

refunds of additional tax withholdings based on imputed income. I understand that the Office of Employee Benefits will not coordinate such refunds if it is not notified within 31 days of the date of the marriage.

I (employee) understand that if my domestic partnership ends, I will not be able to drop my domestic partner from my coverage until open enrollment (for effect January 1 of the following year) unless my domestic partner experiences a qualifying status change.

**3. Acknowledgment of Imputed Income and Additional Tax Withholding**

I (employee) understand that pursuant to federal guidance, under the State employee health plan the fair market value of any health coverage extended to my domestic partner will be imputed to me as income on my paycheck. This imputed income will be added to my federal taxable gross wages, State taxable gross wages and social security taxable wages. Additionally, I pay for any coverage provided to my domestic partner on an after-tax basis. I will have additional tax withholdings based on the imputed income and the increased taxable wages due to the reduction in my pre-tax contribution. I understand that the amount of imputed income is generally around \$200 per pay period for medical/prescription, dental and vision coverage, and the amount of the reduction in my pre-tax contribution is generally around \$100 for the same coverage. I understand that this means I will have additional tax withholdings based on approximately \$300 per pay period if my domestic partner is covered under my medical/prescription, dental and vision plans.

**4. Acknowledgment of Timing Rule for Addition of New Domestic Partner**

I (employee) understand that if I drop my domestic partner from my coverage, I will not be able to add a new domestic partner for at least 6 months, assuming my new domestic partner meets all eligibility requirements.

**5. Affidavit Under Penalty of Perjury**

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  
(Employee Name)

foregoing representations, information and documentation provided herein are true, correct, and complete.

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

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

\_\_\_\_\_  
Notary Public

Seal/Stamp:

My Commission Expires: \_\_\_\_\_

State of Rhode Island

County of \_\_\_\_\_

I, \_\_\_\_\_ do hereby under oath depose and say that the  
(Domestic Partner Name)

foregoing representations, information and documentation provided herein are true, correct, and complete.

\_\_\_\_\_  
Domestic Partner Signature

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

\_\_\_\_\_  
Notary Public

Seal/Stamp:

My Commission Expires: \_\_\_\_\_