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 Federal law requires that the fair market value of any State health coverage extended to my domestic partner must be imputed to me as income on my paycheck. I understand that there will be additional tax withholdings based on this imputed income. I understand that the State and/or the Office of Employee Benefits does not provide any guidance on the issue of whether my domestic partner is my tax dependent. I understand that this determination can only be made by a tax professional and/or the IRS and that this determination would be reflected on my annual Federal income tax return as filed with the IRS. I understand that if my domestic partner qualifies as a tax dependent for the applicable taxable year that my tax liability will be adjusted, and any excess tax withholdings can be recouped as part of my tax filing for that taxable year.

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, _____________________

(Employee Name) do hereby under oath depose and say that the 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____.

________________________________________

Seal/Stamp:

Notary Public

My Commission Expires: _____________________
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

Subscribed and sworn to before me in ______________________, Rhode Island on the __________day of _____________, 20___.

____________________________ Seal/Stamp:
Notary Public

My Commission Expires: ______________________