dchr
DC Department of Human Resources

AFFIDAVIT OF EMPLOYEE AND DOMESTIC PARTNER FOR HEALTH BENEFITS ENROLLMENT
District of Columbia Employees' Health Benefits Program

SECTION 1: EMPLOYEE / DOMESTIC PARTNER INFORMATION

Employee Last Name	Employee First Name	Date
Agency Name	**Phone Number**	**Last 4-digits of SSN**

Address:

Domestic Partner Last Name	Domestic Partner First Name	Last 4-digits of SSN

SECTION 2: DECLARATION OF FACT

We depose and attest to the following:

- We are both at least eighteen (18) years of age and competent to contract;
- We are the sole domestic partner of the other person;
- We both share a mutual residence;
- Neither of us are legally married to another person; and
- We are jointly and financially responsible for basic living expenses (defined as the cost of basic food, shelter, and any other expenses of a domestic partnership, which are paid at least in part by a benefit or program for which the partner qualified because of the domestic partnership).

  NOTE: Domestic partners need not contribute equally or jointly to the cost of these expenses, as long as they agree that both are responsible for the cost. Documentation must be provided that clearly indicates jointly financial responsibility.

SECTION 3: HEALTH INSURANCE COVERAGE

- I understand that my domestic partner and his/her dependent child(ren) is/are eligible for enrollment only during open enrollment periods, a qualifying event, or at the time of my hire with the District government.
- I understand that I will assume 25% of the cost of family health insurance coverage for my domestic partner or family member of my domestic partner on an after-tax basis, and that the District government shall pay the remaining 75% of the cost.
- I understand that this Affidavit shall be terminated upon the death of my domestic partner, or by a change in circumstance attested to in this affidavit.
- I agree to provide written notice to the Benefit and Retirement Administration within the D.C. Department of Human Resources (DCHR) if there is any change to the circumstances attested to in this Affidavit, within 30 days of the change. I understand, however, that I will remain responsible for the payment of the premiums for health benefits coverage for my domestic partner and any dependents for a six (6) month period following the termination of the relationship. A certified copy of the statement terminating the domestic partnership filed with the D.C. Department of Health (DOH) shall be provided.

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(CONTINUATION)

SECTION 4: OTHER ACKNOWLEDGEMENTS

- After termination of this Affidavit, I understand that another Affidavit of Domestic Partnership for Health Insurance Benefits cannot be filed until the end of a six (6) month period following final termination of domestic partnership.
- We understand that the information contained in this Affidavit will be held confidential and will be subject to disclosure only upon express written authorization, or as required by law.
- We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit of Domestic Partnership for Health Benefits Enrollment.
- We understand that willful falsification of information contained in this Affidavit may result in termination of our enrollment by the health care plan we select for coverage.
- We also certify under penalty of perjury under the laws of the District of Columbia, that the foregoing is true.

Signature of Employee **Date**

Signature of Domestic Partner **Date**

Acknowledge of Receipt (DCHR Director or Designee) **Date**