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AFFIDAVIT OF DOMESTIC PARTNERSHIP

We, _____ and _____ certify that we are domestic partners in accordance with the following criteria and eligible for benefits coverage under the University's benefit programs:

- 1. We are each other's sole domestic partner and intend to remain so indefinitely.
- 2. We are jointly responsible for each other's common welfare, share financial obligations and share our primary residence. We have resided together for at least six (6) continuous months prior to the date of this affidavit. We will provide evidence of joint responsibility. Joint responsibility may be demonstrated by the existence of either (check I or II):

_____ I. A civil union licensed under state law (civil union is defined as a legally recognized union between same sex partners), OR

_____ II. Two or more of the following (please check at least two items that apply):

- _____ A. Domestic Partnership Agreement or Relationship Contract.
- _____ B. Joint mortgage or joint ownership of primary residence.
- _____ C. Two of:
 - _____ 1. Joint ownership of motor vehicle.
 - _____ 2. Joint checking account.
 - _____ 3. Joint credit account.
 - _____ 4. Joint lease.
- _____ D. The Domestic Partner has been designated as a beneficiary for employee's will, retirement contract, or life insurance.

- 3. We are:
 - not married to anyone, and
 - each at least eighteen (18) years of age, and
 - mentally competent to consent to contract, and
 - not related by blood to a degree of closeness, which would prohibit marriage in the State of Maine.

We understand that domestic partners are subject to the other eligibility provisions of the University's benefit plans. For example, new employees, birth or adoption of children, marriages, and domestic partnership are all subject to a thirty-one (31) days enrollment period limit from the date of eligibility. No individual may have coverage as both an employee and a dependent or as a dependent of two individuals covered under the health plan.

To the extent that coverage for a domestic partner is financed by the University, the employee is taxed on the fair market value of the coverage. Fair market value is based on what the employee's cost would have been at group rates. The value of the coverage must be reported as income on the employee's W-2 Form and the University must withhold Federal Insurance Contribution Act (FICA) on that imputed income. Nontaxable health coverage can only be provided to an employee's legal spouse or a dependent as defined under Sec. 152 of the Internal Revenue Code.

The employee agrees to notify the University in writing within thirty-one (31) days of any termination of our domestic partnership. A written termination statement shall affirm that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner. Under the University's current insured group health plan with Anthem Blue Cross and Blue Shield, a domestic partner is eligible for continued health coverage under COBRA upon termination of a domestic partnership.

We certify that the foregoing is true and correct. We, the undersigned employee of the University of Maine System and the Domestic Partner, understand that falsification of information contained in this Affidavit may lead to disciplinary action, up to and including immediate termination of employment, and may subject us to civil action to recover any losses, including reasonable attorney's fees, in addition to an obligation to repay benefits received.

Note: Signing of this Affidavit may affect important legal rights. Please consult your attorney.

Signature of Employee Date:_____.

Certified, subscribed and sworn to before me this _____ day of _____, _____

STATE OF MAINE
County of _____

Notary Public

[SEAL] My commission expires:_____

Signature of Domestic Partner Date:_____.

Certified, subscribed and sworn to before me this _____ day of _____, _____

STATE OF MAINE
County of _____

Notary Public

[SEAL] My commission expires:_____

Partner and/or Partner's Child(ren) Certification as a Tax-Qualified Dependent

Based on consultation with a tax advisor, I certify that the [] Partner and/or [] Child(ren) whom I am enrolling for coverage is my legal tax dependent under IRS Sec. 152. I understand that falsification of this certification of dependency status may result in disciplinary action, up to and including immediate termination of employment, as well as potential charges of tax fraud. I agree to notify the University immediately of any change in this tax status.

Signature of Employee Date:_____.

The Affidavit and accompanying documentation have been reviewed.

- Eligibility: Approved
 Not Approved

Signature of Approving Officer Date:_____.

Printed Name

Title