Affidavit of Domestic Partnership

DECLARATION:

WE _____ (EMPLOYEE), AND _____ (DOMESTIC PARTNER), EACH CERTIFY AND DECLARE UNDER PENALTY OF PERJURY AND THE LAWS OF THE STATE OF CALIFORNIA, THAT THE STATEMENTS BELOW ARE TRUE AND CORRECT.

Section 1. We are domestic partners in accordance with the following criteria, and that our domestic partnership (please check *applicable box)* either:

Section 1A ☐ Is publicly registered under state or local law, as substantiated by the attached certification.

OR

Section 1B ☐ Satisfies all of the following criteria of the Cedars-Sinai domestic partnership definition, as set forth below, regardless of whether the domestic partnership is between persons of the same or opposite sex:

1. We have been sharing a common residence for at least six months and intend to do so indefinitely.
2. We are not related by blood to a degree of closeness that would prohibit marriage.
3. We have assumed mutual responsibility for basic living expenses.
4. We are at least age 18 and capable of consenting to the domestic partnership.
5. Neither of us is married to anyone else or in a declared domestic partnership with anyone else.
6. We met these requirements on or about _____, 20_____.

Section 2. We agree to notify the MBC HR Employee Benefits Help Desk in writing as soon as possible, but no later than 30 days, after our domestic partnership is terminated or dissolved, by completing an Affidavit of Termination of Domestic Partnership (available from the MBC HR Employee Benefits Help Desk).

Section 3. We understand that failure to give Cedars-Sinai written notice of the termination or dissolution of our domestic partnership in accordance with Section 2 could be cause for discipline against an employee, including termination of employment. In addition, such action may constitute insurance fraud, and Cedars-Sinai has the right to recoup from either of us, including by way of payroll deduction, the cost of any benefits provided to an individual who is not the domestic partner of a Cedars-Sinai employee.

Section 4. We understand that civil action may be brought against one or both of us for any losses (and attorneys' fees and costs) due to any false statement in this Declaration or due to failure to notify Cedars-Sinai of a termination or dissolution of domestic partnership in accordance with Section 2.

Section 5. We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.

EMPLOYEE AND DOMESTIC PARTNER SIGNATURES

The certifications and declarations herein are true, correct and contain no material omissions of fact to our best knowledge and belief and are made under penalty of perjury. Both partners must sign. Signatures of both partners must be notarized if Section 1B above is checked.

Employee's signature

Print or type name and employee ID number

Date signed by employee

Domestic partner's signature

Print or type name

Date signed by domestic partner

Mailing address:

Street

City

State

ZIP code

EMPLOYEE ACKNOWLEDGEMENT OF IMPACT ON TAXES

I understand that the total contribution for my domestic partner's coverage may be taxable to me as imputed income under state and/or federal law. Any imputed income will be added to my second paycheck each month and will result in applicable Social Security and Medicare taxes being withheld for that income. Any imputed income will be included on my W-2 at year end and will be included as part of my taxable income for state and federal income tax calculations.

Employee's signature

Print or type name and employee ID number

Date signed by employee

NOTARIZATION IS REQUIRED IF SECTION 1B ABOVE IS CHECKED

State of _____

County_____

On _____, before me, _____, Notary Public,

personally appeared _____

Personally known to me (or proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument) and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____

Signature of Notary Public

[PLACE NOTARY PUBLIC SEAL HERE]

RETURN THE COMPLETED FORM ANY OF THE FOLLOWING WAYS:

Web:	Cedars-Sinai.MyBenefitChoice.com Log in > Get Answers > Upload Documents You can upload the following types of files: pdf, .jpg, .png, .bmp, .gif, .doc, or .docx
Fax:	206-299-3158
Email:	hwformsprocessing@milliman.com
Mail:	Cedars-Sinai HR Benefits Department c/o MBC HR Employee Benefits Help Desk PO Box 600610 Dallas, TX 75360-0610