Transit Employees'
HEALTH AND WELFARE PLAN
2701 WHITNEY PLACE • SUITE 100 • FORESTVILLE, MARYLAND 20747
PHONE: (301) 568-2294 • FAX: (301) 568-7302
WEBSITE: http://tehw.org • EMAIL: info@tehw.org

Affidavit of Domestic Partnership

I, _____, Employee Number _____ the eligible participant in the Transit Employees' Health and Welfare Plan, and _____, being duly sworn, depose and certify as follows:

That we are in a committed long-term relationship as Domestic Partners;

That we have shared the same regular and permanent residence for at least one (1) year in a committed relationship and intend to do so indefinitely;

That we are each eighteen years of age or older and are mentally competent to enter into a contract;

That we are not related by blood to a degree of closeness which would prohibit marriage under the laws in the state in which we reside;

That we have a close and committed personal relationship, and we are each other's sole domestic partner not married to or partnered with any other spouse, spouse equivalent or domestic partner;

That we are engaged in a committed relationship of mutually caring and support, are jointly responsible for each other's common welfare and living expenses, are financially interdependent and have provided documentation to the Transit Employees Health and Welfare Office of at least three of the following arrangements; at least one of which is date one year prior to the date of this affidavit

- Common ownership of Real Property (joint deed or mortgage agreement or common leasehold interest in such property)
- Common ownership of a motor vehicle
- Proof of joint bank account(s) or joint credit account(s)
- Proof of designation as the primary beneficiary for the Life Insurance or Retirement Benefits or primary beneficiary designation under a partner's Will.
- Assignment of a durable property Power of Attorney or a Healthcare Power of attorney.

That if we reside in a jurisdiction which permits registration of Domestic Partners, we declare that we have registered and will provide evidence of such registration;

That we understand that continuation of medical coverage under COBRA is not available to the Domestic Partner or the Domestic Partner's eligible dependent children;

That we have provided true and accurate required documentation of our relationship.

That we understand and have considered the possible legal and tax consequences of signing this Affidavit and acknowledge that we do so voluntarily;

That each of us understands and agrees that in the event any of the statements set forth herein are not true the insurance or health care coverage for which this Affidavit is being submitted may be rescinded and/or each of us shall jointly and severally be liable for any expenses incurred by the Transit Employees' Health and Welfare Plan; and,

That I, _____, further understand that I must notify Transit Employees' Health and Welfare Plan if the Domestic Partnership relationship described in this Affidavit terminates and that I must file an Affidavit of Termination of Domestic Partnership with the Transit Employees' Health and Welfare Plan within thirty (30) days from the date of said termination.

We declare that the statements in this Affidavit are true to the best of our knowledge and belief.

By:_____ _____
Signature of Employee/Subscriber Printed Name of Employee/Subscriber

_____ _____
Signature of Domestic Partner Printed Name of Domestic Partner

Sworn to before me this _____ day of _____, 20_____.

_____
NOTARY PUBLIC