



HEALTH AND WELFARE PLAN



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Affidavit of Domestic Partnership

I, _____, Employee No. _____ as the eligible participant in the Transit Employees' Health and Welfare Plan, and _____, being duly sworn, depose and certify as follows:

We have an intimate relationship and a Domestic Partnership.

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

We are each eighteen years of age or older and are mentally competent to enter into a contract.

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

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.

We are engaged in a committed relationship; jointly responsible for each other's common welfare and living expenses; financially interdependent, and have provided documentation to the Transit Employees Health and Welfare Office of at least three of the following arrangements.

- 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.

If we reside in a jurisdiction that permits registration of Domestic Partners, we declare that we have registered and will provide evidence of such registration.

We understand that continuing medical coverage under COBRA is not available to the Domestic Partner or the Domestic Partner's eligible dependent children.

We have provided true and accurate required documentation of our relationship.

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

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forth herein are not true, the insurance or health care coverage for which this Affidavit is being submitted may be rescinded, and each of us shall jointly and severally be liable for any expenses incurred by the Transit Employees' Health and Welfare Plan; and,

I, _____, further understand that I must notify Transit Employees' Health and Welfare Plan if the Domestic Partnership Relationship described in this Affidavit terminates. Also, I understand 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 accurate 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