TRANSIT EMPLOYEES' HEALTH AND WELFARE PLAN
2701 Whitney Place #100
Forestville, Maryland 20747
P: 301-568-2294 F: 240-745-3956 E: INFO@TEHW.ORG

AFFIDAVIT OF DOMESTIC PARTNERSHIP

I, _____, Employee No. _____, as an eligible participant in the Transit Employees' Health and Welfare Plan, and I, _____, being duly sworn, hereby certify and declare the following:

We are in an intimate and committed Domestic Partnership.

We have shared the same permanent residence for at least one (1) year and intend to continue doing so indefinitely.

We are each at least eighteen (18) years of age and are mentally competent to enter into this agreement.

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

We are in a close and exclusive relationship, and neither of us is married to, or in a domestic partnership with, anyone else.

We are jointly responsible for each other's common welfare and living expenses, are financially interdependent, and have provided the Transit Employees' Health and Welfare Office with documentation of at least three (3) of the following:

- Joint ownership of real property (e.g., deed, mortgage, or lease agreement)
- Joint ownership of a motor vehicle
- Joint bank account(s) or joint credit account(s)
- Designation of one another as primary beneficiary on a life insurance policy, retirement plan, or will
- Assignment of a durable power of attorney or health care power of attorney in favor of one another

If residing in a jurisdiction that permits registration of Domestic Partnerships, we confirm that we are registered and will provide proof of registration upon request.

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

We affirm that all documentation provided to the Transit Employees' Health and Welfare Office regarding our relationship is true and accurate.

We acknowledge that we have considered the potential legal and tax consequences of signing this affidavit and do so voluntarily.

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We understand and agree that if any statement herein is found to be false, coverage provided under this Plan may be rescinded, and we shall be jointly and severally liable for any resulting expenses incurred by the Transit Employees' Health and Welfare Plan.

I, _____, further agree to notify the Transit Employees' Health and Welfare Plan if this Domestic Partnership is terminated and will file an Affidavit of Termination of Domestic Partnership within thirty (30) days of the date of termination.

We declare, under penalty of perjury, that the statements contained in this Affidavit are true and correct to the best of our knowledge and belief.

This Affidavit must be signed in the presence of a duly authorized notary public.

_____ _____
Name (Printed) Date

_____ _____
Signature Date

_____ _____
Notary Public Signature Date

_____
Notary Printed Name

_____
Registration/Serial Number, Notary ID,
or Bar Number (where applicable)