

SKIDMORE

C O L L E G E

AFFIDAVIT OF DOMESTIC PARTNERSHIP

I. DECLARATION

Employee: _____
Last Name, First Name, Middle Initial Social Security Number

Domestic Partner: _____
Last Name, First Name, Middle Initial Social Security Number

We provide this information to be used by the College for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our expressed written authorization or when required by law.

- We are each other’s sole domestic partner and intend to reside together in the same residence indefinitely;
- We are jointly responsible for each other’s common welfare and financial obligations*;
- We reside together in the same residence and have so resided for the last six months;
- We are both over 18 years of age and are mentally competent to consent to contract;
- We are not related by blood to any degree that would bar marriage in the state of legal residence;
- Neither of us is legally married to any other person;
- We have an exclusive mutual commitment similar to that of marriage and it is our intent that substantially all property acquired during our domestic partnership shall be considered joint property in the same manner as if we were married.

*Jointly responsible for each other’s common welfare and financial obligations means the cost of basic food, shelter, and any other expenses of a domestic partner which are paid at least in part by a program or benefit for which the partner qualified because of the domestic partnership. The individuals need not contribute equally or jointly to the costs of these expenses as long as they agree that both are responsible for the cost.

II. DOCUMENTATION

We are domestic partners who reside together in the same residence and are financially interdependent. We submit original documents of three of the following items (at least two of the three items must be from List A as proof of financial interdependence for at least six months): (Note: original documents will be copied only to the extent necessary to document receipt and returned to you). All documents must show they have been in existence at least 6 months

List A	List B
Joint obligation of a loan	Joint bank account
Joint ownership of our residence	Joint credit or charge card(s)
Designated as beneficiary on each other’s life insurance policy, retirement benefits, or will; or executor of each other’s will	Status as authorized signatory on the partner’s bank account, credit card or charge card
Designate as executor on each other’s will	Other proof establishing economic interdependence
Joint lease agreement	
Joint renter's or home owner's insurance policy	
Health care proxy	

Please note if you choose to submit a beneficiary designation on the other's life insurance, retirement benefits, or wills, both the employee AND the domestic partner must show these documents designating each other to have this item count as one proof of interdependence.

III. CHANGE IN DOMESTIC PARTNERSHIP

I agree to notify Human Resources if there is any change in our status as domestic partners or the dependency status of children of the employee's domestic partner as certified in this statement which would make us no longer eligible for benefits. We will notify the College within thirty (30) days of such change by filing a "[Notice of Termination of Domestic Partnership](#)" with the Human Resources. The Notice of Termination shall affirm the date that the domestic partnership status terminated.

IV. ACKNOWLEDGEMENTS:

- We acknowledge that our domestic partnership has been entered into willingly and voluntarily;
- We have provided the information in this affidavit for use by the College for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that the information contained in this affidavit is confidential and will not be released by the College unless expressly authorized by either or both of us, except as otherwise required by law or by the health insurance carrier that provides us coverage;
- We understand that this affidavit may create between us certain contractual rights and legal obligations and that the College has encouraged us to seek independent legal advice about those rights and obligations;
- We understand that any additional cost incurred by the College as a direct result of enrolling a domestic partner and his or her child(ren) in the health care plan or tuition programs will result in a taxable benefit to the employee;
- We understand that any employee cost sharing will be based on the level of coverage including the Domestic Partner and/or their children;
- We acknowledge that under New York State law, a domestic partner and/or their children can not be added to the employee's dental coverage;
- We acknowledge that any health care or dependent care costs incurred by the domestic partner and children can not be reimbursed to the employee through his or her flexible spending account(s);
- We acknowledge that the domestic partner and child(ren) are not entitled to health care continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) in the event the employee separates from employment;
- We acknowledge that registration of domestic partnership will be required for coverage under the health care plans effective with the open enrollment period preceding January 1. New employees may apply upon hire or during any subsequent open enrollment period;
- We acknowledge that any person/employer/company who suffers any loss due to any false statements contained in this affidavit may bring a civil action against either or both of us to recover their losses, including attorney's fees; and that any false statement could result in disciplinary action to the employee, including termination of employment;
- We declare, under penalty of perjury, that the statements and information provided herein are true and correct.

I am applying for the following benefits for my domestic partner:

(Check all that apply)

_____ Health Care Coverage

_____ ID Card Privileges

_____ Tuition Programs

Employee's Signature

Date

Domestic Partner's Signature

Date

Employee's/Domestic Partner's Home Address

Witnessed by Human Resources' Staff or Notary Public

Date

TO BE COMPLETED BY HUMAN RESOURCES

_____ Approved by Human Resources

_____ Declined by Human Resources

Human Resources' Staff Signature

Date

Title