Affidavit of Domestic Partnership

Employer use only
Approved by: _____
Approved date: _____
Effective date: _____

Use this form to add a domestic partner to your coverage. Do not submit this form if you have a domestic partnership through Registered Certificate.

To add a domestic partner by affidavit to your coverage, you must submit this affidavit to your employer within five business days of the electronic enrollment date, or if enrolling with a paper form, within five business days of the date your enrollment form was received by your employer. If this affidavit is not received by your employer within this timeframe, coverage for your domestic partner will not become effective.

To add a domestic partner by affidavit, both you and your domestic partner cannot be married to anyone or have had a spouse or another domestic partner within the last six months. If either of you were married, the six month period starts on the first of the month following the date of divorce.

Employers must calculate and apply applicable imputed value tax for domestic partners covered under OEBB benefit plans.

Submit this completed form to your employer.

I am submitting my Affidavit of Domestic Partnership

◯ During the open enrollment period	◯ Outside the open enrollment period
You must have jointly shared the same permanent residence for at least six months immediately preceding the date of this affidavit and intend to continue to do so indefinitely. Please indicate how long you have lived together:	You must have jointly shared the same permanent residence for six months immediately preceding the date of this affidavit and enrolled in coverage within 31 days of the six month anniversary date. Please indicate how long you have lived together:

Employee information

Employer			
Last name	First name		M.I.
Employee ID, E number or Social Security number		Gender ◯ M ◯ F ◯ Other	Date of birth *(mm/dd/yyyy)*
Home phone number		Work phone number	
Work email		Personal email	
Address ☐ Check if new address			Apartment or space#
City	State	ZIP	County

Domestic partner information

Date of eligibility for coverage *(mm/dd/yyyy)*		
Last name	First name	M.I.
Employee ID, E number or Social Security number	Gender ◯M ◯F ◯Other	Date of birth *(mm/dd/yyyy)*

You must report to your employers' benefits administrator within 31 days after a person enrolled as your spouse/domestic partner or dependent child becomes ineligible for benefits. If you make this report on time, the change will be effective the first of the month after your report. If you do not report this change on time, OEBB may consider that an intentional misrepresentation of a material fact, for which OEBB may terminate the family members' coverage effective the first of the month after eligibility was lost.

Declaration of domestic partnership and employee signature

I, _____, certify that _____
(print name of employee) *(print name of domestic partner)*

and I are, and have been, each other's partner in a domestic partnership, as defined below. For the purposes of this affidavit, a "domestic partnership" is one consisting of two persons in which the following applies:

1. Both are at least 18 years of age;
2. Are responsible for each other's welfare and are each other's sole domestic partner;
3. Are not married to anyone and either has not had a spouse or another domestic partner within the prior six months (if previously married, the six month period starts on the final date of divorce);
4. Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
5. Have jointly shared the same regular and permanent residence for at least six months; and
6. Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household (financial information must be provided if requested).

This affidavit terminates upon the death of the signing employee's domestic partner or by a change in circumstances attested to in this affidavit. The signing employee must notify their employer within 31 days after such death or change, by completing a Termination of Domestic Partnership form and a midyear change form. After submitting the forms, the employee may not file a new Affidavit of Domestic Partnership for the purpose of enrolling a new partner for six months from the date the Termination of Domestic Partnership form is received by the employer.

We certify that the foregoing is true and accurate to the best of our knowledge.

Employee signature	Date
Domestic partner signature	Date
Employer (received by)	Date

Submit this completed form to your employer.
Do not submit this form to OEBB.