DOMESTIC PARTNER AFFIDAVIT

Instructions: 1. This form cannot be completed or submitted online.
2. Print and complete by hand - print clearly using blue or black ink.
3. Items marked with an asterisk (*) are required fields.
4. When complete, fax to the number below. Be sure to retain original and the fax receipt for your records.
5. Effective date on the form is the date you and your Domestic Partner entered/registered into the Domestic Partner Relationship. Dependents will be added to medical and/or dental plans as defined by the benefit plan documents.
6. If you are just registering the domestic partner relationship then you will only need to complete pages 2 and 3.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* First Name	Middle Name	* Last Name

General Information:

To enroll your domestic partner [and child(ren) of your domestic partner] in medical and dental benefits, please carefully read the information below, and complete the form as directed.

A. This enrollment form also applies to your domestic partner and the child(ren) of your domestic partner who are enrolled in the Dependent Life and Accidental Death and Dismemberment Insurance plans, if applicable.

B. You need to notify your benefits representative if there is any change of circumstances attested to in the Kaiser Permanente Affidavit of Domestic Partnership. To terminate your domestic partnership and enrollment of your domestic partner in these benefits, you need to file a Kaiser Permanente Termination of Domestic Partnership or provide a copy of the notice of termination of domestic partnership filed with a local or state government to your benefits representative within thirty-one (31) days of such change.

C. You cannot file another Kaiser Permanente Affidavit of Domestic Partnership until six (6) months after the date of filing a Kaiser Permanente Termination of Domestic Partnership. (No waiting period is applicable in the event of the death of your domestic partner.)

D. The Kaiser Permanente Affidavit of Domestic Partnership shall terminate upon the death of your domestic partner.

E. Willful falsification of information on the Kaiser Permanente Domestic Partner Affidavit or in the local or state government domestic partner registry will lead to termination of benefits coverage and may lead to disciplinary action, up to and including recovery of the cost of any benefits provided as well as discharge from employment.

Important information about changes to the definition of dependent: Recent laws have changed the federal tax code sections that define who qualifies as a dependent with regard to tax-free coverage for certain employee benefits, including medical and dental benefits. A child of a domestic partner cannot be claimed as a dependent of an employee if the child can be the "qualifying child" of the domestic partner or another taxpayer. In most cases, the child of a domestic partner cannot be the dependent of an employee unless that child has been adopted by the employee.

If you have previously enrolled a domestic partner's child as a dependent, that dependent may no longer qualify for tax-free medical and dental coverage. Due to the change in the law, the fair market value of this coverage may now be considered taxable income.

1. DOMESTIC PARTNER

Select One:

☐ My domestic partner and I have registered our relationship with a local or state government domestic partner registry. Attached is a copy of our certified registration.

☐ My domestic partner and I have not registered our relationship with a local or state government domestic partner registry so we are registering our relationship by completing the attached Kaiser Permanente Affidavit of Domestic Partnership.

* Employee Signature

* Date (mm-dd-yyyy)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

* First Name	Middle Name	* Last Name
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)

2. DOMESTIC PARTNER AND/OR CHILDREN OF DOMESTIC PARTNER ACKNOWLEDEMENT OF SECTION 152 - INTERNAL REVENUE CODE

If I check "Yes" next to the name of my domestic partner and/or the children of my domestic partner listed below, I certify s/he is my legal tax dependent as defined under the Internal Revenue Code section 152. This means that (1) s/he receives over half of her/his support from me, (2) his/her principal place of residence is my home, (3) s/he is a member of my household and, in the case of his/her child(ren), that, (4) my domestic partner's child is not the "qualifying child" of my domestic partner or any other taxpayer. As a result, the fair market value* of medical and dental benefits provided by Kaiser Permanente shall **not** be taxable to me. I will notify my benefits representative immediately of any change in this tax dependent status.

If I check "No" next to the name of my domestic partner and/or the children of my domestic partner listed below, I understand s/he does not constitute my legal tax dependent as defined under Internal Revenue Code section 152. As a result, the fair market value of medical and dental benefits provided by Kaiser Permanente on his/her behalf shall be taxable to me and such taxes will be withheld from my paycheck every pay period.

If your domestic partner qualifies as your legal tax dependent, but his/her child(ren) do not, check "Yes" for your domestic partner and "No" for his/her child(ren). If you fail to complete this section, Kaiser Permanente will withhold payroll taxes based on the fair market value of the dependent benefits for your domestic partner and his/her children.

☐ I have registered my domestic partner relationship with the **State of California Partner Registry** in accordance with the guidelines established by the state of California. As such, the fair market value of medical and dental benefits covering my domestic partner will be exempt from California State income and SDI taxes.

Domestic Partner

* Name (First, Middle, Last)			
*** Sex** ☐ Female ☐ Male	*** IRS Dependent** ☐ Yes ☐ No	* Date of Birth (mm/dd/yyyy)	* Social Security Number - (SSN) (xxx-xx-xxxx)

Domestic Partner's Children

Name (First, Middle, Last)			
Sex ☐ Female ☐ Male	**IRS Dependent** ☐ Yes ☐ No	Date of Birth (mm/dd/yyyy)	Social Security Number (xxx-xx-xxxx)
Name (First, Middle, Last)			
Sex ☐ Female ☐ Male	**IRS Dependent** ☐ Yes ☐ No	Date of Birth (mm/dd/yyyy)	Social Security Number (xxx-xx-xxxx)

Use additional forms for more members.

Employee Signature	Date (mm-dd-yyyy)	Domestic Partner Signature	Date (mm-dd-yyyy)

DOMESTIC PARTNER AFFIDAVIT

* First Name	Middle Name	* Last Name
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)

I, _____, and I _____
Print Name Print Domestic Partner's Name

certify, under penalty of perjury under the laws in force in the state in which I reside, that we are domestic partners and that we:

1. Live together, sharing the same living quarters as our primary residence, in an intimate,committed relationship of mutual caring;
2. Have no other domestic partner at this time;
3. Are responsible for each other's basic living expenses during our domestic partnership, and agree to be financially responsible for any debt each other incurs as a result of Kaiser Permanente's extension of benefits of either of us;
4. Are not married to anyone;
5. Are each 18 years of age or older;
6. Are not related to each other as a parent, brother or sister, half brother or sister, niece, nephew, aunt, uncle, grandparent, or grandchild;
7. Have not been covered by Kaiser Permanente sponsored benefits with another domestic partner at any time during the last six (6) months (this last condition does not apply if your prior domestic partner is deceased; if so, cross this out).

Employee Signature	Date (mm-dd-yyyy)	Domestic Partner Signature	Date (mm-dd-yyyy)

Employee / Domestic Partner Information

Employee Social Security Number (SSN) (xxx-xx-xxxx)	Phone Number (###) ###-####	Domestic Partner SSN (xxx-xx-xxxx)

NOTARIZATION

State Of	County Of	Notary Public - (Print Name)

On_____ before me, _____ personally appeared
(insert name and title of the officer)

_____ and _____
(insert name of employee) (insert name of domestic partner)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

Seal	**X** _____ Notary Public Signature
	My Commission Expires (mm/dd/yyyy)

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