Affidavit of Domestic Partnership

Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

_____
Employee/Retiree's Name

DECLARATION

We certify that _____ is a Domestic Partner of _____
Domestic Partner's name (please print) Employee/Retiree's name (please print)

in accordance with the following eligibility criteria. We certify we met the following eligibility criteria for establishing a

Domestic Partnership as of _____ .
Date

- We have lived together for at least twelve months.
- We are not married to anyone else nor have another Domestic Partner.
- We are at least 18 years of age and mentally competent to consent to contract.
- We reside together in the same residence and intend to do so indefinitely.
- We have an exclusive mutual commitment similar to that of marriage.
- We are jointly responsible for each other's common welfare and share financial obligations

In addition to this Affidavit, we have attached at least two of the documents listed below.

- Joint mortgage or lease
- Designation of Domestic Partner as beneficiary for life insurance and retirement contract
- Designation of Domestic Partner as primary beneficiary in employee's or insured's will.
- Durable property and health care powers of attorney.
- Joint ownership of motor vehicle, joint checking account or joint credit account

Complete and attach the notarized Affidavit of Domestic Partnership to your Benefit Event or Enrollment Form. Notary's seal and signature must be clearly visible.

CHANGE IN DOMESTIC PARTNERSHIP

We agree to notify the State of Maryland within thirty (30) days of any change in Domestic Partnership status which would make the Domestic Partner no longer eligible for benefits (e.g., a change in joint residency,) by filing a Statement of Termination of Domestic Partnership. The Statement of Termination shall affirm that the Domestic Partnership status is terminated as of the date of execution specified therein and that a copy has been mailed to the other party by the party authorizing the action.

Upon termination of this Affidavit of Domestic Partnership (evidenced by a Statement of Termination of the Partnership signed by the Insured), I _____ agree that another Affidavit of Domestic Partnership cannot be filed for a minimum of twelve months.

ACKNOWLEDGEMENTS

1. We have provided this information in this Affidavit for the sole purpose of determining our eligibility for Domestic Partnership health benefits.
2. Willful falsification of information within this document may lead to disciplinary action, loss of insurance coverage, and/or the recovery of the cost of benefits received related to such falsification.

_____
Employee/Retiree Signature Date

_____
Employee/Retiree Social Security number

_____
Employee and Domestic Partner Home Address

_____
Domestic Partner Signature Date

On this _____, day of _____, 20 _____ , before me personally came _____, to me known to be the individual described as "Employee/Retiree/Insured and the individual described as Domestic Partner in the above document entitled "AFFIDAVIT OF DOMESTIC PARTNERSHIP" and who executed same as a free and voluntary act for the uses and purposes stated herein.

_____
Notary Public My Commission Expires