AFFIDAVIT OF DOMESTIC PARTNERSHIP

MULTNOMAH BAR ASSOCIATION GROUP INSURANCE PLANS

SECTION ONE

I, _____ and _____ are either:
(Name of Employee) (Name of Domestic Partner)

1. Registered as Domestic Partners with the State of Oregon ("Registered Domestic Partnership"), or;
2. In an "Unregistered Domestic Partnership," meaning we:
   - are each eighteen (18) years or older;
   - share a close personal relationship and are responsible for each other's common welfare;
   - are each other's sole domestic partner;
   - are not legally married to anyone nor have had another domestic partner within the previous six (6) months;
   - are not related by blood closer than would bar marriage in the states of Oregon and Washington;
   - share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
   - are jointly financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and medical expenses. (Note: Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost);
   - were mentally competent to consent to contract when our domestic partnership began.

SECTION TWO

1. I, the employee, understand that my domestic partner is eligible for enrollment only at the time I become eligible for coverage; or during the annual open enrollment period designated by the MBA; or if my domestic partner has had an involuntary loss of coverage.
2. If I am in a Registered Domestic Partnership, I understand that my domestic partner's children are eligible for enrollment on the same terms as the children of an employee's spouse.
3. If I am in an Unregistered Domestic Partnership, I understand that children of my domestic partner are eligible if they meet the requirements for my eligible dependent as defined in the Group Insurance contract.
4. I understand that coverage for my domestic partner shall terminate upon a change in circumstances attested to in Section One of this Affidavit.
5. I agree to provide written notice to the plan administrator, Alliant Insurance Services, Inc., if there is any change of circumstances attested to in the Affidavit within 30 days of change by filing a "Statement of Termination of Domestic Partnership."
6. After the termination of an Unregistered Domestic Partnership, I understand that an application to add a new unregistered domestic partner cannot be filed until the next open enrollment period established by the MBA, following six (6) months from the filing of a "Statement of Termination of Domestic Partnership" with the plan administrator, Alliant Insurance Services, Inc.

SECTION THREE

1. We understand that the information contained in the Affidavit will be held confidential and will be subject to disclosure only upon the express written authorization or as required by law.
2. We understand that we are responsible for any losses, including reasonable attorney fees and court costs, because o false information contained in the Affidavit of Domestic partnership and that any such false information may result in our termination of enrollment under any health care plan that we select.
3. We understand that under applicable federal and state income tax law, payments for health coverage of a domestic partner (registered or unregistered) may not be eligible under a Section 125 Plan (if available through the group) and further that coverage of the non-employee domestic partner could result in additional taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes).
4. We understand that, in addition to the contract eligibility requirements of my group for domestic partner coverage, there are terms and conditions of coverage set forth in the group contract of each health care plan offered through my group to which we agree to be bound.
5. We also certify under penalty of perjury under the laws of the state issuing the contract that the foregoing is true and accurate to the best of our knowledge.

Signature of Employee	Date	Signature of Domestic Partner	Date
Street Address	City	State	Zip

STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____, affirm that the Affidavit of Domestic Partnership
Name of Employee

Attested to and signed by me on _____, shall be and is terminated as of this date.
Date of Affidavit

Termination is due to:

_____ Dissolution of Registered Domestic Partnership

_____ Termination of Unregistered Domestic Partnership because of a change in one or more of the following circumstances originally attested to in Section One of the Affidavit of Domestic Partnership. (Circle all that apply)

1. We were not both eighteen (18) years or older when our partnership began;
2. We no longer share a close personal relationship or are no longer responsible for each other's common welfare;
3. We are no longer each other's sole domestic partner;
4. One or both of us is legally married to someone else or has had another domestic partner within the previous six (6) months;
5. We are related by blood closer than would bar marriage in the state of Oregon or Washington;
6. We no longer share the same regular and permanent residence, or no longer have the current intent to continue doing so indefinitely;
7. We are no longer jointly financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and medical expenses. (Note: Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost);
8. We were not mentally competent to consent to contract when our domestic partnership began.

_____ Death of Domestic Partner.

I understand that if I terminate an Unregistered Domestic Partnership, I cannot file a Statement of Domestic Partnership to enroll a new Unregistered Domestic Partner until the next open enrollment established by the Multnomah Bar Association, following six (6) months from the receipt of this statement by the plan administrator, Alliant Insurance Services, Inc.

_____ _____
Signature of Employee Date

Received by:

_____ _____
Date