Affidavit of Registered Domestic Partner

To enroll your Domestic Partner in any of the Santa Clara University sponsored Health and Welfare plans, please complete this form and submit it, along with your Enrollment Application(s), to the Department of Human Resources.

This form must be submitted during open enrollment *or* within thirty (30) days of establishing or terminating your Domestic Partner relationship.

Because we require the social security number, ***please do not submit via email***.

Employee Name:_____

Registered Domestic Partner Social Security Number:_____

Address:_____

City: _____State_____Zip_____

Name of Registered Domestic Partner:_____

We declare that we are registered through the State of California as registered domestic partners, certifying the following:

- ❑ Neither my partner is nor am I married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.

- ❑ My partner and I are *not* related by blood in a way that would prevent us from being married to each other in the state of California.
- ❑ Both my partner and I are at least eighteen (18) years of age.

- ❑ Both my partner and I are capable of consenting to the domestic partnership

We understand that Santa Clara University reserves the right to request a copy of our Domestic Partner Registration certificate.

We provide the information in this affidavit to be used by the University for the sole purpose of determining our eligibility for domestic partner Health and Welfare benefits.

Updated 8/12/2019

We understand that registered domestic partners are subject to the same window period governing all other employees who are covered by or applying for benefit plan coverage. Any children, new employees, adoptions, new marriages, and registered domestic partnerships are subject to a thirty (30) day limit on the enrollment period from the date of eligibility.

We agree to notify the Department of Human Resources within thirty (30) days of the termination of our domestic partnership. A written notice shall be provided to the Department of Human Resources, Benefits, attesting that a Notice of Termination of Domestic Partnership has been filed and provided to the other domestic partner.

We understand that under applicable federal and state income tax law that payments for health coverage of a domestic partner may not be eligible for treatment under the Section 125 plan and that coverage of the non employee domestic partner could result in additional imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes).

We affirm, under the penalty of perjury, that the assertions in this Affidavit are true and accurate to the best of our knowledge. We understand that the willful falsification of information contained in this Affidavit may result in our termination of enrollment by the plan providers which we have selected for coverage.

_____	_____		
Signature	(Last)	(First)	(Middle)
_____	_____		
Signature	(Last)	(First)	(Middle)

Date of Registered Domestic Partnership