Maine Municipal
Employees Health Trust
60 COMMUNITY DRIVE
AUGUSTA, MAINE 04330-9486
1-800-452-8786

AFFIDAVIT OF DOMESTIC PARTNERSHIP

We, _____ and _____ (domestic partners), after being first duly sworn depose and attest to the following:

- We are at least 18 years of age and we are mentally competent to contract.
- Neither of us is legally married to or separated from another person.
- We are sole domestic partners, we have been sole domestic partners since _____ (month/day/year), and we intend to remain sole partners.
- We have been legally domiciled together for at least [12] months.
- We are not related by blood to a degree of closeness that would prohibit marriage in the State of Maine.
- Neither of us has covered another individual or has been covered by another individual as a domestic partner or a legal spouse in a [health] or [dental] or [vision] insurance policy in the preceding [12] months. We understand that domestic partners cannot enroll together for [12] months following the termination of coverage of a prior domestic partner or legal spouse.
- We are jointly responsible for each other's common welfare as evidenced through a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, and/or powers of attorney authorizing each of us to act on behalf of the other. Maine Municipal Employees Health Trust reserves the right to request, at a future time, one of the previously mentioned documents.
- We understand that a domestic partner enrolled as a dependent ceases to be an eligible member on the first of the month following the termination of a domestic partnership and that we are required to submit an Application of Change within 31 days of the termination of a domestic partnership.

_____ _____ _____
Date Subscriber Signature Print Name

_____ _____ _____
Date Domestic Partner Signature Print Name

STATE OF _____ _____ , ss

On this _____ day of _____ , 20 _____ , personally appeared the above named _____ and _____ , and swore to the truth of the foregoing. Before me,

_____
Notary Public/Attorney at Law My Commission Expires: _____

We understand that domestic partners are subject to the other eligibility provisions of the Health Trust benefit plans.

We agree to notify the Maine Municipal Employees Health Trust and the employee's employer within thirty (30) days of the termination of our domestic partnership. A written termination statement shall be provided and shall affirm that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner.

We certify, under penalty of perjury, that the foregoing is true and correct. We, the undersigned employee and the Domestic Partner, understand that falsification of information contained in this Affidavit may cause immediate termination of Health Trust health and/or dental plan coverage, and may subject us to civil action to recover any losses, including reasonable attorney's fees incurred by the Maine Municipal Employees Health Trust for benefits provided under its health and/or dental plans. We also understand that falsification of information contained in this Affidavit may lead to disciplinary action, up to and including immediate termination of the employee's employment.

_____ _____

Signature of Employee Date

_____ _____

Signature of Domestic Partner Date

A. Dependent Child Certification

I, _____ certify that my Partner's child(ren) named below meet the following requirement:
Subscriber Name

1. I, the subscriber, have a court-appointed legal relationship with the child(ren) (i.e., adoption, guardianship), and my Partner is the biological parent, or legal guardian of the child(ren).

Partner's Dependent Child(ren)

_____	_____	_____
Last Name	First Name	M.I.
_____	_____	_____
Last Name	First Name	M.I.
_____	_____	_____
Last Name	First Name	M.I.
_____	_____	_____
Last Name	First Name	M.I.

I understand that falsely certifying as to dependent's eligibility or failure to inform the Health Trust when a dependent no longer meets applicable eligibility requirements may cause immediate termination of Health Trust health and/or dental plan coverage, and may subject me to civil action to recover any losses, including reasonable attorney's fees incurred by the Maine Municipal Employees Health Trust for benefits paid on behalf of the dependent child(ren) named above under its health and/or dental plans. I also understand that falsely certifying as to a dependent's eligibility or failure to inform my employer when a dependent no longer meets applicable eligibility requirements may result in disciplinary action, up to and including immediate termination of employment.

_____ _____

Signature of Employee Date

Approved by the Maine Municipal Employees Health Trust

By: _____ _____

Signature Date

_____

Title

The following section is for certification to an employer of the legal tax dependent status of a domestic partner.

B. Partner Certification as a Tax-Qualified Dependent

Based on consultation with a tax advisor, I certify that the previously named person whom I am enrolling for coverage is my legal tax dependent as defined in the IRS Code Section 152. I understand that falsification of this certification of dependency status may result in disciplinary action, up to and including immediate termination of employment, as well as potential charges of tax fraud. I agree to notify my employer immediately of any change in this tax status.

By: _____ _____

Signature of Employee Date