

**LOS RIOS COMMUNITY COLLEGE DISTRICT  
AFFIDAVIT OF DOMESTIC PARTNERSHIP  
EMPLOYEES**

**I. AFFIRMATION OF DOMESTIC PARTNERSHIP**

We, \_\_\_\_\_, (Los Rios employee), and

\_\_\_\_\_ (domestic partner), the undersigned, certify that we are domestic partners and that we:

1. Are each eighteen (18) years of age or older;
2. Share a close personal relationship and are responsible for each other's common welfare;
3. Are each other's sole domestic partner;
4. Are not married to anyone nor have we had another domestic partner within the last six (6) months;
5. Are not related by blood closer than would bar marriage in the State of California;
6. Have jointly shared the same regular and permanent residence for at least six (6) months immediately preceding the date of this Affidavit with the intent to continue doing so indefinitely;
7. Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. 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.

**II. DECLARATION OF MEMBER**

1. I understand my domestic partner is eligible for enrollment in a medical plan within 30 days of submitting a completed Affidavit to the Employee Benefits Department. I understand that if I enroll my domestic partner within 30 days of submitting the completed Affidavit, coverage for my domestic partner would begin on the first day of the month following the date the Affidavit is signed. I further understand that I may enroll my domestic partner in a medical plan during the District's annual October open enrollment period. I understand that enrollment changes made during open enrollment are effective December 1.
2. I understand that eligible dependent children of my domestic partner may be enrolled in a medical plan within 30 days of submitting the Affidavit, within 30 days of adoption or birth, or during the District's annual October open enrollment period.
3. I understand that my domestic partner or eligible dependent children of my domestic partner may be enrolled in the dental plan within 30 days of submitting a completed Affidavit, or within 30 days of adoption or birth. I further understand that I cannot enroll my domestic partner or my domestic partner's eligible dependent children in the dental plan during the annual open enrollment period as Delta Dental does not participate in open enrollment.

4. I understand that children of my domestic partner are eligible if they meet the requirements of an eligible dependent as defined by the District's medical/dental carriers.
5. I understand that in the event of my death, my covered domestic partner and any covered dependent children of my domestic partner may elect COBRA continuation coverage on a self-pay basis.
6. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change in circumstances attested to in this Affidavit.
7. I Agree to file a Statement of Termination of Domestic Partnership with the Employee Benefits Department within 30 days of any change to circumstances attested to in this Affidavit. I further understand that failure to provide notice within 30 days may be considered a violation of the employment contract. In such cases the District may implement any appropriate remedy including, but not limited to, requiring the employee to reimburse the District for the value of all insurance extended to the domestic partner.
8. I understand that, after such termination, another Affidavit of Domestic Partnership cannot be filed with the Employee Benefits Department until such time the conditions in Section I have been met.

### **III. DECLARATION OF PARTNERS**

1. We understand that the information contained in the Affidavit relates to eligibility for benefits under a group medical or dental plan. Any other use of this information will be subject to disclosure only upon either of our written authorizations or as required by law.
2. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit of Domestic Partnership.
3. We understand that under applicable federal and state income tax law, payments for medical and/or dental coverage for a domestic partner are not eligible for pre-tax treatment. In addition, coverage of the domestic partner will result in additional imputed taxable income to the employee, and related withholding of payroll taxes (including income and Social Security taxes, if applicable) by the employer. There are some exceptions to the imputed income and you should check with your tax professional.
4. We understand that in addition to the eligibility requirements of the medical and dental carriers, there are terms and conditions of coverage set forth in the Service Agreement of each plan offered by Los Rios to which we agree to be bound.
5. We understand that willful falsification of information contained in this Affidavit will result in termination of enrollment pursuant to this agreement by the health plans.

# CALIFORNIA JURAT WITH AFFIANT STATEMENT

State of California

County of \_\_\_\_\_

} ss.

\_\_\_\_\_  
Signature of Document Signer No. 1

\_\_\_\_\_  
Signature of Document Signer No. 2

Subscribed and sworn to (or affirmed) before me on this \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_, by  
Date Month Year

(1) \_\_\_\_\_,  
Name of Signer

- Personally known to me  
 Proved to me on the basis of satisfactory evidence to be the person who appeared before me (.) (,) (and

(2) \_\_\_\_\_,  
Name of Signer

- Personally known to me  
 Proved to me on the basis of satisfactory evidence to be the person who appeared before me.)

\_\_\_\_\_  
Signature of Notary Public

Place Notary Seal Above

## OPTIONAL

*Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.*

### Further Description of Any Attached Document

Title or Type of Document: \_\_\_\_\_

Document Date: \_\_\_\_\_ Number of Pages: \_\_\_\_\_

Signer(s) Other Than Named Above: \_\_\_\_\_

**RIGHT THUMBPRINT  
OF SIGNER #1**

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**RIGHT THUMBPRINT  
OF SIGNER #2**

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