State of Colorado
Affidavit of Same-Gender Domestic Partnership

INSTRUCTIONS

1. Complete this Affidavit form to establish eligibility for your same-gender domestic partner to be enrolled in the medical, dental, optional life and/or Flexible Spending Account (FSA) employee group benefit plans offered by the State of Colorado.
2. Review, sign and date this form and have this form notarized.
3. Submit this form to your agency benefit administrator with supporting documentation.

EFFECTIVE DATE

Effective Date of Declaration of Same-Gender Domestic Partnership _____

ELIGIBILITY CRITERIA

In order to enroll a same-gender domestic partner in a state employee group benefit plan, an employee must meet the following two eligibility requirements:

1. The employee must be enrolled in the medical, dental, optional life and/or Flexible Spending Account (FSA) plan, and

2. The same-gender domestic partner must be an adult, at least eighteen (18) years of age, the same gender as the employee, has shared an exclusive, committed relationship with the employee for at least one year with the intent for the relationship to last indefinitely, is not related to the employee by blood to a degree that would prohibit marriage pursuant to Section 14-2-110, C.R.S., and is not married to another person.

The term “eligible children”, for the purpose of determining eligibility for eligible children of an eligible same-gender domestic partner, is defined in the same manner as the term “eligible children” is defined in the State of Colorado’s medical, dental, and optional life employee group benefit plans for determining coverage for the children of a spouse.

ACKNOWLEDGEMENTS

A. We understand that this declaration of same-gender domestic partnership is for the purpose of establishing eligibility for enrollment in the medical, dental, optional life and/or the Flexible Spending Account (FSA) employee group benefit plans offered by the State of Colorado and for no other purpose.

B. We understand that the declaration of same-gender domestic partnership may have implication to the taxability of the state employee group benefit plans and/or to the taxability of benefits provided.

C. We understand that before signing this Affidavit form, it is our responsibility to seek competent legal, tax and accounting advice concerning such matters.

D. We acknowledge that the State of Colorado has provided us with no advice in this regard.

SUPPORTING DOCUMENTATION

An employee seeking to cover a same-gender domestic partner must provide at least one form of supporting documentation from the list below. Please check the box and attach supporting documentation.

Provide one of these documents

___ Bank statement indicating joint ownership of a bank account.
___ Ownership of a joint credit card.
___ Joint ownership or holding of investments.
___ A joint mortgage or lease.
___ Evidence of a joint obligation on a loan.
___ Mutually granted durable power of attorney.
___ Joint ownership of a residence.
___ Affidavit by a creditor able to testify to the partner's financial interdependence.
___ Evidence of a common household (e.g., utility bills, telephone bills).
___ Joint ownership or lease of a motor vehicle.
___ Evidence of other joint responsibility, such as child care (e.g., school documents, guardianship).
___ Mutually granted authority to make healthcare decisions (e.g., healthcare power of attorney).
___ Authorized signatory on the partner's bank account, credit card or charge card.
___ Beneficiary designation under the other's life insurance policy, will or executor of each other's will.
___ Same-sex marriage certificate.
___ Other proof establishing economic interdependence.

NOTIFICATION OF TERMINATION OF SAME-GENDER DOMESTIC PARTNERSHIP

A. The employee agrees that, if this same-gender domestic partnership is terminated, the employee will notify the State of Colorado within thirty-one days of such termination by completing and submitting a "Termination of Same-Gender Domestic Partnership Affidavit" form to the employee's agency benefit administrator, and by making a benefit election change in the state's electronic benefit enrollment system within the proper timeframe. A minimum of one year (12 months) must elapse before another same-gender domestic partner may be added to the employee's coverage.

B. The employee understands that the termination of medical, dental, optional life and/or Flexible Spending Account (FSA) coverage obtained as a result of this declaration will be in effect until the last day of the month during which the same-gender domestic partnership ends or at such time as coverage terminates in accordance with the terms and conditions of applicable plan documents and policies.

DECLARATION OF SAME GENDER DOMESTIC PARTNERSHIP

For the purpose of establishing eligibility for enrollment in a medical, dental, optional life and/or Flexible Spending Account (FSA) employee group benefit plan offered by the State of Colorado and for no other purpose, we make the following declaration:

I, _____, am currently a State of Colorado employee and

_____, is my same-gender domestic partner who desires to be covered as an eligible dependent pursuant to the rules and procedures of the State of Colorado Department of Personnel & Administration, hereby declare that:

1. We are adults, at least eighteen years of age;
2. We are the same gender;
3. We have shared an exclusive, committed relationship for at least one year with the intent for the relationship to last indefinitely;
4. We are not related by blood to a degree that would prohibit marriage pursuant to Section 14-2-110, C.R.S.; and
5. Neither one of us is married to another person.
6. Neither one of us is in a "Civil Union Partnership" with another person.

AUTHORIZATION AND SIGNATURE

Upon signing this Affidavit form we represent that the information contained herein is true and complete to the best of our knowledge; and that this agreement becomes effective on the date entered below. By signing this Affidavit form, we understand that the State of Colorado reserves the right to request verification of the information contained in this Affidavit.

DATE

DEPARTMENT / DIVISION

EMPLOYEE'S NAME (Please Print)

X
EMPLOYEE'S SIGNATURE

EMPLOYEE'S DATE OF BIRTH

EMPLOYEE'S SOCIAL SECURITY #

DOMESTIC PARTNER'S NAME (Please Print)

X
DOMESTIC PARTNER'S SIGNATURE

DOMESTIC PARTNER'S DATE OF BIRTH

DOMESTIC PARTNER'S SOCIAL SECURTY #

NOTORIZATION – FOR BENEFIT ENROLLMENT PURPOSES ONLY

Sworn to before me this _____ day of _____, 20_____

X_____
Notary Public

My Commission Expires

Notary Public's Address

It is unlawful for any person to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, electronic benefits enrollment system, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application for benefits or claim for benefits. Penalties may include imprisonment, fines, denial of enrollment in any or all of the state's employee group benefit plans, civil damages, termination of enrollment in any or all of the state's employee group benefit plans, or as provided in regulations, statutes, and written directives.