Print form

Clear form

CONFIDENTIAL

COUNTY OF SONOMA

AFFIDAVIT OF DOMESTIC PARTNERSHIP BENEFITS

1. I_____ and I,_____
(**print** – employee name) (**print** - non-employee name)

are domestic partners and hereby declare that we meet the following criteria:

(i) We are both 18 years of age or older.

(ii) Neither of us is married.

(iii) We are not related to each other in a way which would bar marriage in California.

(iv) Neither of us is acting under fraud or duress, and both are competent to contract.

(v) We reside together.

(vi) We agree to be jointly responsible for each others' basic living expenses during the Domestic Partnership.

(vii) Any different domestic partnership of which either of us was previously a member ended more than six months ago, except that this requirement does not apply if the earlier domestic partnership ended because of the death of one of its members.

2. We share the same principal place of residence and we intend to continue to do so indefinitely. Currently our address is: _____.

3. By signing this Affidavit, we agree that while we are living together, we are economically responsible to each other and for each others' medical expenses and other common necessities of life to the same extent as if we were in a legally recognized spousal relationship.

4. Each of us agrees to immediately notify the County of Sonoma Auditor Payroll Department in writing if there is any change of circumstances (except a change of address) attested to in the Declaration or in this Affidavit by filing a Statement of Termination of Domestic Partnership. Such termination statement shall be on a form provided by the County and shall affirm under penalty of perjury that the domestic partnership is terminated and that a copy of the termination statement has been mailed to the other partner. Notice of termination must be filed within 30 days of the termination of the partnership.

5. Each of us understands that domestic partnerships are subject to the same enrollment periods and procedures governing all other employees' spouses who are covered by or applying for health, dental, vision or life insurance coverage. Enrollment forms for Health and Welfare plans must be completed and submitted to the Risk Management Division before benefits are initiated.

6. Each of us understands that under applicable federal and state income tax law, payments for health coverage of the non-employee domestic partner may not be eligible for pre-tax treatment 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) on such amounts.

7. Each of us understands that, if either of us has made a false statement regarding his or her qualification as a domestic partner or has failed to comply with the terms of the Affidavit and the County suffers any loss thereby, the County may bring a civil action against either or both of us to recover its losses, including reasonable attorneys' and court costs.

8. Each of us understands that in addition to the eligibility requirements for domestic partnership coverage, there are terms and conditions of coverage set forth in the service agreement of each health and welfare plan offered through the County. Each of us acknowledges that, depending on the health and welfare plan we select, the applicable service agreement may include, for example and without limitation: (1) a requirement that each of us arbitrate any and all claims, including malpractice claims, against the health and welfare plan we choose and its related organizations and providers; and, (2) the right of the health and welfare plan to terminate coverage on the grounds set forth in the service agreement, including, without limitation, termination due to fraud or misrepresentation of eligibility. By executing this Affidavit, each of us agrees to be bound by the terms and conditions of coverage of the health and welfare plan selected, as set forth in the application service agreement, including the arbitration clause, if any.

9. Each of us provides this information in this Affidavit to be used by County for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that this information will be held confidential, except as necessary in order to process the benefits, and will be subject to disclosure only upon our express written authorization or pursuant to a court order.

10. Each of us understands that this application process, by submission of this Affidavit of Domestic Partnership Benefits, does not substitute and is not equivalent to registration with the State of California, pursuant to *Family Code Section 297 et seq.* While some commonalities exist in terms of benefits under both registration processes, some important distinctions remain.

11. Each of us declares under penalty of perjury that the assertions in the Affidavit are true and correct to the best of our knowledge.

DATED: _____

Employee signature	Date of birth
Employee ID number (employee)	
Non-employee signature, domestic partner	Date of birth

Date Received by Auditor Central Payroll:	(Date)
Date acknowledgement letter sent to employee:	(Date)

CONFIDENTIAL

COUNTY OF SONOMA
TERMINATION OF DOMESTIC PARTNERSHIP

Employee Name: _____ Employee ID Number: _____

Domestic Partner's Name: _____

Check the appropriate box:

☐ My domestic partnership to the aforementioned individual was terminated effective_____ (date). I have mailed a copy of this form to the aforementioned partner.

☐ My domestic partnership to the aforementioned individual was dissolved due to his/her death on _____ (date).

☐ My domestic partnership to the aforementioned individual should be cancelled as we were legally married on _____ (date).

This termination notice is not equivalent to and does not replace the termination procedure for registered domestic partners under the *California Domestic Partner and Responsibilities Act of 2003 (Family Code Section 297 et seq.).*

I affirm under penalty of perjury that this information is true.

Signature: _____ Date: _____

NOTE: If your domestic partner (or dependent of the domestic partner) was enrolled for health and/or dental coverage, you must complete health/dental change of status forms to delete the ineligible dependents or change the tax status, if applicable. Contact the Risk Management Division or your Departmental Payroll Clerk for the necessary forms.

FOR COUNTY USE ONLY

Date Received by Auditor Central Payroll:	_____ (Date)
Date acknowledgement letter sent to employee:	_____ (Date)