

Drake University

Affidavit of Domestic Partnership

We, _____, and
(Name of Employee, please print)

_____ certify that:
(Name of domestic partner, please print)

1. We are at least eighteen (18) years of age or older and are of the same gender.
2. We have executed a notarized "relationship contract", which (a) obligates each partner to provide support for the other partner, and (b) acts as each other's sole domestic partner indefinitely.
3. We are unable to qualify for coverage as common law spouses.
4. Neither of us is legally married nor covered under another domestic partner arrangement with Drake University.
5. We are not related by blood closer than would bar marriage in the state of Iowa and are mentally competent to consent to contract.
6. We have been residing together for at least six (6) continuous months immediately prior to filing this affidavit.
7. We understand that domestic partners are subject to the same enrollment period rule governing all other employees who are covered by, or applying for the benefit plan coverage.
8. We understand that we must notify the Drake University Benefits Office of any change in our meeting the eligibility requirements and that failure to continue to meet the conditions of eligibility will result in termination of coverage for the Domestic Partner.
9. We understand that any person, employer, or company who suffers any loss because of false statements contained in this "Affidavit of Domestic Partnership" may bring a civil action against us to recover their losses, including reasonable attorney fees.
10. We agree to notify the Drake University Benefits Office within thirty (30) days of the termination of our domestic partnership. A written statement will be provided to the Benefits Office that will affirm that the partnership is terminated. We understand that a copy of the termination will be mailed to the other partner unless both signatures are on the written notification.

11. We understand that after a signed statement of termination of a domestic partnership has been filed with the Drake University Benefits Office, another "Affidavit of Domestic Partnership" cannot be filed for at least twelve (12) months.

12. We understand that because the IRS does not recognize domestic partners as dependents; insurance premium, non-covered medical, dental, prescription drugs and vision care and dependent care expenses for a domestic partner do not qualify under the University sponsored Flexible Spending Account.

13. We understand that coverage for the Domestic Partner will terminate on the date the relationship ends.

14. We provide the information in this affidavit to be used by the Drake University Benefits Office for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our expressed written authorization or pursuant to a court date.

15. We affirm, under penalty of perjury, that the ascertainments in this affidavit are true to the best of our knowledge.

(Signature of Employee)

(Signature of Domestic Partner)

(Employee's Social Security No.)

(Domestic Partner's Social Security No.)

(Date)

(Date)

(Employee's Date of Birth)

(Domestic Partner's Date of Birth)

State of _____

County of _____

Sworn to and subscribed before me the ____ day of _____, 20____, and such a person did take an oath and: ____ is personally known to me, or ____ produced _____ as identification.

(Signature of Notary Public)

(Print or Type Name of Notary Public)

(Commission Expires)

(SEAL)