COMMUNITY COLLEGE
system of New Hampshire

AFFIDAVIT OF SAME-SEX DOMESTIC PARTNERSHIP

We, _____, and
(Name of CCSNH Employee)

_____, certify that:
(Name of Same-Sex Domestic Partner)

1. We are at least eighteen (18) years of age or older and are mentally competent to consent to contract.

2. We are each other's sole same sex domestic partner, responsible for each other's common welfare and financial obligations.

3. We are not married to another person, nor do we qualify for coverage as a common-law spouse.

4. We are not related by blood closer than would bar marriage in the State of New Hampshire.

5. This relationship has been in existence for the past period of six (6) consecutive months or more.

6. We share a residence.

7. One of the following four (4) conditions must exist (please check those that apply; confirming documentation may be solicited):

❒ **A.** We have one of the following arrangements:

1. Joint ownership of a motor vehicle
2. Joint bank account(s)
3. Joint credit card account(s)
4. Lease for a residence identifying both parties as tenants
5. Joint mortgage or ownership of a residence (home, condominium or mobile home).

❒ **B.** The domestic partner has been designated as a beneficiary for:
☐ 1. CCSNH Life Insurance
☐ 2. Death Benefit from Retirement Plan
☐ 3. Employee's Will or Trust

❒ **C.** A "relationship contract" has been executed which obligates each of the parties to provide support for the other party and provides, in the event of termination of the domestic partnership, for a substantially equal division of any property acquired during the relationship.

❒ **D.** Proof of a legally issued and recognized civil marriage or civil union.

8. We understand that any qualified family status changes are subject to a thirty-one (31) day enrollment period limit, commencing from the date of the event.

9. We agree to notify the CCSNH Human Resources Office within thirty-one (31) days of the date of the termination of our domestic partnership. A written termination statement shall be provided to the CCSNH Human Resources Office, affirming that partnership has terminated. In the case that the partnership has terminated, a copy of the termination statement has been mailed to the other partner.

10. Another affidavit for benefit coverage cannot be applied for until six (6) months after a statement of termination of the previous partnership has been filed with the CCSNH Human Resources Office.

11. We understand that any person, employer, or company who suffers any loss because of false statements contained in the Affidavit of Same Sex Domestic Partnership may bring a civil action against us to recover their losses, including reasonable attorney fees.

12. We understand that electing Same Sex Domestic Partner benefit coverage may have legal implications, including taxability of benefits provided, and that before signing this Affidavit we should seek competent legal and accounting advice concerning such matters.

13. We provide the information in this affidavit to be used by the CCSNH Human Resources Office for the sole purpose of determining our eligibility for same sex 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 order.

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

_____	_____
Signature of CCSNH Employee	Signature of Domestic Partner
xxx-xx-_____	xxx-xx-_____
Social Security Number (last four digits)	Domestic Partner Social Security Number (last four digits)
_____	_____
Date of Birth	Domestic Partner's Date of Birth
_____	_____
Date	Date

Community College System of New Hampshire
Affidavit of Same Sex Domestic Partnership
To Be Completed by a Notary Public

State of: _____

County of: _____

_____, after first being duly sworn, declares that:
(CCSNH Employee)

The assertions in this declaration are true to the best of my knowledge. I understand that this form is not an application for medical/dental coverage and that the purpose of this form is to establish the eligibility of persons named herein for same sex domestic partner coverage provided under the Community College System of New Hampshire.

Subscribed and Sworn before me by _____ this
(CCSNH Employee)

_____ day of _____ 20 _____.

_____
Notary's Signature

(Notary Seal)