Human Resources
Benefits Office

Montefiore

AFFIDAVIT OF DOMESTIC PARTNERSHIP

Associate Information (please print)

Name _____
(Last) (First) (M.I.)

Street Address _____

City, State, Zip Code _____

Social Security # _____ Birth Date _____

Declaration

I, _____ being duly sworn, deposes and declares that I am an associate of
(Name of MMC Associate)
Montefiore Medical Center (MMC). and I make this Affidavit in support of my application for designation of
_____ as eligible for domestic partnership status under the Policy of MMC which
(Name of Domestic Partner)
provides for the extension of benefits available to spouses of Montefiore associates to eligible domestic partners of MMC associates. We cohabit and reside together and intend to do so indefinitely and share the common necessities of life. The effective date of qualification of this domestic partnership under Montefiore's Policy for Domestic Partners is _____. We understand that supporting documentation, e.g. evidence of common ownership or rental of one primary residence, a joint bank account, and/or joint credit cards and proof of responsibility for each other's common welfare, as set forth in the Policy is required by MMC.

Status

Both _____ and I, _____ are at least eighteen (18) years of age
(Name of MMC Associate)
or older, and of legal age of consent and competent to enter into a contract in the state in which we reside. Neither of us is married to anyone. We are not related by blood to a degree of closeness that would otherwise bar marriage in the State in which we legally reside. We are each other's sole domestic partner and intend to remain so indefinitely and are responsible for each other's common welfare. We understand that domestic partners are subject to the same 30-day "window" period governing all other MMC associates who are covered by or applying for health plan coverage. i.e., new associates, new children, adoptions, and new marriages are all presently subject to a 30-day limit on the enrollment period, beginning on the date of the event.

Change In Domestic Partnership

We agree to notify MMC within 30 days of any change in our domestic partnership, For example, a change in residence, marital status or if we are no longer each other's sole domestic partner. If, as a result of a change in circumstance MMC informs me that _____ is no longer eligible as a domestic partner for MMC Spousal Benefits.
(Name of Domestic Partner)
I agree to file a Statement of Termination of Domestic Partnership ("Termination Statement") as required by MMC and in accordance with the rules for filing such statements subject to my rights under The Employee Retirement Income Security Act of 1974. I understand that the Termination Statement shall be in the form of an affidavit sworn under penalty of perjury to the effect that the partnership is terminated and that a copy of the Termination Statement has been mailed to

_____.
(Name of Domestic Partner)

Sworn Statement

We understand that any entities or persons including but not limited to MMC and/or any MMC associate who suffers any loss because of any false statements contained in this Affidavit may bring a civil action suit against us to recover their respective losses, including reasonable attorney's fees. We declare under penalty of perjury under the laws of the State of that the statements above are true and correct.

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

Associate Signature._____ Associate Name (print) _____

State of _____

County of _____

On the day _____ of _____, 20__, before me personally appeared

_____, known to me to be the person who executed the foregoing document.

_____

Notary Public for Associate

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

Domestic Partner Signature _____; Domestic Partner Name (print) _____

State of _____

County of _____

On the day _____ of _____, 20__, before me personally appeared

_____, known to me to be the person who executed the foregoing document.

_____

Notary Public for Domestic Partner