

## IMPORTANT NOTICE

To: Plan Participants

From: Board of Trustees

**Re: Domestic Partner Eligibility**

Please be advised that qualified domestic partners of eligible participants of the Teamsters Managed Health Care Trust Fund, may become eligible for Health and Welfare benefits subject to satisfaction of certain enrollment and tax payment requirements.

The enrollment procedure for a domestic partner will require the following documentation:

- Completion of a new enrollment form,
- Completion of an Affidavit of Domestic Partnership,
- Documentation that the domestic partnership is registered with a government entity,
- Evidence showing joint financial responsibility such as copies of a mortgage, lease, rental agreement, bank statement or other such documents.

Because the Internal Revenue Service (IRS) does not consider Domestic Partners as dependents, the benefits provided to Domestic Partners are taxed. The value of the imputed income resulting from the domestic partners benefits will be reported to your employer for inclusion on your W-2 Form.

Upon Satisfaction of the enrollment procedure, a domestic partner will be granted eligibility on the same basis, and provided the same benefits, as is an eligible spouse. Children of domestic partners may also qualify for eligibility in the same manner step-children qualify for coverage. Please refer to your Summary Plan Description (SPD) and Plan Document for a complete explanation of Health and Welfare benefits.

If you have any questions, please call the Plan Administrative Office at (800) 924-1226.

## AFFIDAVIT OF DOMESTIC PARTNERSHIP

I, \_\_\_\_\_ (herein referred to as the Employee), and  
\_\_\_\_\_(herein referred to as the Partner) hereby declare under penalty of  
perjury that we are Domestic Partners with the meaning of the following declaration:

1. We have had an intimate, committed relationship of mutual caring for a period of at least six (6) months immediately prior to the date of this Affidavit, and intend to remain sole Domestic Partners indefinitely (Note: Domestic partners include individuals who may marry but have chosen not to.); and
2. We share the same principal residence, with the current intent to continue doing so indefinitely. We agree to be jointly financially responsible for “basic living expenses”, defined as the cost of basic food, shelter, and medical expenses. (Note: Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.) If we cannot provide documentation that we have registered our domestic partnership with a government entity, we agree to provide the Fund’s Administrative Office with the following evidence showing joint responsibility, as requested: such evidence may include a request for a copy of a mortgage, lease or rental agreement, vehicle title of ownership, bank statement and/or utility statement showing both the Employee’s and Partner’s names or an Unincorporated Nonprofit Association (UNA) Form issued by the office of the Secretary of State in California. In addition, we agree to provide the following evidence showing designation of domestic partner as a beneficiary, as requested: such evidence may include the Employee’s life insurance, retirement benefits and/or will. We also agree that we share financial obligations and any third party who is owed these expenses can collect from either of us; and
3. We are both 18 years of age or older and neither of us is married. Neither of us is related by blood to the other, such as parent, brother, sister, half brother or sister, niece, nephew, aunt, uncle, grandparent or grandchild; and
4. Neither of us has a different Domestic Partner or spouse now, and neither of us has had a different Domestic Partner in the last six (6) months.
5. I understand further that children of my domestic partner are eligible if they are unmarried; meet the Fund’s definition of an eligible dependent; and reside in the household (with two exceptions, full-time student at an accredited school or court ordered dependent coverage).
6. I understand that coverage for domestic partner shall terminate upon a change in circumstance attested to earlier of this Affidavit.
7. Each of us agree to provide written notice to the Administrative Office of Labor Alliance Managed Trust Fund if there is any change of circumstances attested to in this Affidavit within 30 days of the change by filing a “Statement of Termination of Domestic Partnership”.
8. After such termination, I understand that an application to add a new domestic partner cannot be filed earlier than six months from the filing of a Statement of Termination of Domestic Partnership with the Fund.
9. We understand the Fund will compute the value of the imputed income resulting from the domestic partner benefit and will notify my employer of this imputed income which will be included on my W-2 from that employer.

**IMPORTANT**

WE ACKNOWLEDGE THAT A PARTNER DOES NOT QUALIFY AS A DEPENDENT OF THE EMPLOYEE AS DEFINED BY SECTION 152 (A) OF THE INTERNAL REVENUE CODE. BY REQUESTING ENROLLMENT OF A PARTNER UNDER THE DOMESTIC PARTNER AFFIDAVIT, EACH OF US UNDERSTANDS THAT THE LABOR ALLIANCE MANAGED TRUST FUND WILL REPORT IMPUTED TAXABLE INCOME TO THE EMPLOYER FOR INCLUSION ON THE W-2 FORM.

Each of us understands these rules and declares that the statements outlined above are true and correct with regard to the Employee's and Partner's Domestic Partner relationship. We understand that if the Fund, Trustees of the Fund or their agents suffer any loss due to an inaccurate statement in this Affidavit, they may bring civil action against either or both of us to recover their losses, including reasonable attorney's fees.

We understand that the information contained in this Affidavit will be held confidential and will be subject to disclosure only upon the express written authorization of the Employee or as required by law.

**In providing domestic partner benefits, the Trustees recognize that participants may have tax or benefit implications. You should contact your tax advisor for professional advice as to how domestic partner coverage may affect your personal situation.**

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Signature of Domestic Partner

\_\_\_\_\_  
SSN of Employee

\_\_\_\_\_  
SSN of Domestic Partner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires \_\_\_\_\_

**TEAMSTERS MANAGED HEALTH CARE TRUST FUND**  
**STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP**

I, \_\_\_\_\_, affirm that the Affidavit of Domestic Partnership attested to and signed by me on \_\_\_\_\_ shall be and is terminated as of this date.  
Date of Affidavit

Termination is due to:

\_\_\_\_\_ Termination of domestic partnership because of a change in one or more of the circumstances attested to in Section One of the Affidavit.

\_\_\_\_\_ Death of domestic partner.

I understand that I cannot file an Affidavit of Domestic Partnership to enroll a new domestic partner until six (6) months following the receipt of this Statement by the Fund.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

Received by:

\_\_\_\_\_  
Fund Representative

\_\_\_\_\_  
Date