DECLARATION OF DOMESTIC PARTNERSHIP

I. DECLARATION:

We, _____, and _____,
(Employee Name and Employee # - Print) (Domestic Partner (DP) Name - Print)

each certify and declare that we are domestic partners in accordance with the following criteria:

II. STATUS:

1. We cohabit and have resided together in the same residence/household for at least six consecutive months and intend to do so indefinitely.

2. We have not been previously legally married to each other while covered under the Metropolitan Solutions Plan.

3. Neither of us is legally married (as defined by federal tax law) to, in a committed relationship with, or legally separated without dissolution of marriage from, anyone else nor have we had another domestic partner or spouse within the prior six months. (This condition will be waived if your previous domestic partner has died.)

4. We are both at least eighteen (18) years of age and mentally competent to consent to a contract.

5. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we reside.

6. We are not in this relationship solely for the purpose of obtaining benefits coverage.

7. We are each other's sole domestic partners and intend to remain life partners indefinitely. Although not defined as spouses under federal tax law, we are engaged in a committed relationship of mutual caring and support. We are jointly responsible for our common emotional, physical, and financial welfare and support. Our interdependence is demonstrated by the following documents, which were not created solely to fulfill the requirements below.

You must provide supporting documentation from each of the three categories listed below - Category 1, Category 2 AND Category 3. In each category check the applicable boxes and attach copies of the supporting documentation for each check box.

Category 1 **(Required for all Applicants and must be dated at least 6 months before application date)**

- ☐ Common ownership of real property (joint deed, mortgage agreement or mortgage payment coupon) or a common leasehold interest in property. This must be dated at least 6 months prior to applying for this coverage. *Submit mortgage payment coupon, copy of the Deed, or entire lease agreement for your current primary residence;*

Category 2 **(two required)**

- ☐ Last Will and Testament naming each other as heir to no less than 50% of the estate
  Submit a copy of your Last Will and Testament AND a copy of your DP's Last Will & Testament,

- ☐ Proof of joint bank accounts
  Submit Bank statement for your primary checking/savings account;

- ☐ Proof of joint credit accounts
  Submit a copy of the credit card or a home equity line of credit statement. Note: American Express does not consider your account to be a joint account even if you completed a joint credit application. An approved signer on your account is not the same as a joint account holder,

EMPLOYEE NAME

EMPLOYEE #

Category 3 **(two required)**

- ☐ Common ownership of a motor vehicle *Submit a copy of the vehicle registration or title;*
- ☐ Driver's license listing a common address *Submit a copy of your Driver's License AND a copy of your DP's License showing physical address, no P.O. Boxes;*
- ☐ Appointment of each other in durable property powers of attorney or health care powers of attorney *Submit a copy of your power of attorney AND a copy of your DP's power of attorney,*
- ☐ Life insurance, retirement plan, and other benefit plan forms naming each other as primary beneficiary *Submit a copy of your policy beneficiary AND a copy of your DP's policy beneficiary',*
- ☐ State Certified Birth certificate or adoption order showing joint custody of our child (ren);
- ☐ Evidence of a cultural ceremony of commitment as life partners or state certified marriage certificate;
- ☐ Other shared loan agreements, contracts, or legal documents reflecting our relationship as domestic partners *Submit copies of documents such as a car loan. Applications for credit and household bills are not acceptable*

III. CHILDREN OF DOMESTIC PARTNER

The following children of my domestic partner meet each of the requirements listed below (please list only those children who qualify):

Name of Child	Date of Birth	SSN	Names of Parents

1. The child is age 19-25 and is not eligible for group health coverage through their employer or the employer of their spouse or domestic partner. This rule applies even if they have chosen not to enroll.

IV. ADDITIONAL CONSIDERATIONS FOR DOMESTIC PARTNERS

1. Internal Revenue Service regulations do not permit expenses for domestic partners to be reimbursed under either the Healthcare Reimbursement or Dependent Care Assistance accounts. The premium value of health coverage provided to a domestic partner and children are included in the employee's wage for tax purposes. The premium value of health coverage is not included in wages if 1) the domestic partner is also a benefit eligible employee and 2) they enroll themselves and their children for coverage as an employee.

2. Domestic partners and their children are not eligible for healthcare continuation through COBRA. Nonetheless, the domestic partner (and the domestic partner's children) of an employee who has died or who is on COBRA may be eligible to continue healthcare coverage. If the domestic partnership terminates continued coverage would also stop.

EMPLOYEE NAME

EMPLOYEE #

V. CHANGE IN DOMESTIC PARTNERSHIP: Please read the following items carefully then initial the line next to each item. If you do not initial these lines your forms will be returned to you for completion.

1. We have an obligation to notify the Metropolitan Solutions Employee Benefit Program by filing a Declaration of Termination of Domestic Partnership if there is any change in our domestic partnership status as attested to in this Declaration that would terminate this Declaration (for example, the death of a partner, a change in residence of one partner, termination of the relationship, etc.). We will notify the Plan within sixty days (60 days) of such change. Failure to so notify the Program may result in termination of employment, as explained in the Employee Agreement.

2. We understand that any benefits obtained as a result of the completion of this Declaration will terminate on the date that the relationship ends, if the Program is notified or not. We agree that each of us will be liable to repay the Program for any benefits received after the relationship ends, and that the Program may collect all benefits improperly paid from either one of us.

VI. ACKNOWLEDGMENTS:

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in this Declaration or for failure to notify the Metropolitan Solutions Employee Benefits Program of changed circumstances as required in Section IV above.

2. We have provided the information in this Declaration for use by the Metropolitan Solutions Employee Benefits Program for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand that the information provided in this Declaration will be treated as confidential but will be subject to disclosure: a) upon the express written authorization of the undersigned employee, b) upon request of the insurer or plan administrator, c) if otherwise required by law, or (d) as otherwise permitted by the privacy rules of the Health Insurance Portability and Accountability Act.

3. We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning the matters disclosed here.

4. We declare under penalty of perjury under the laws of the United States America and the laws of the State of _____[insert state], that the foregoing is true and correct.

5. We understand that §1027 of Title 18 of the United States Code makes it a crime to knowingly make a false statement in any document required to be kept by or certified by a welfare benefit plan administrator. **I further understand that the punishment for violations of this law can be a fine of up to $10.000.00 and imprisonment for as long as five years.** I am also responsible to repay to the Program any benefits paid on behalf of an individual who is ineligible for benefits.

6. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify Metropolitan Solutions of changed circumstances pursuant to Section IV above, may lead to disciplinary action against me, including discharge from employment.

_____ __ / ___ / ___
Employee Name & Employee Number- Print — Date of Birth

_____ __/_____/ ____
Employee - Signature — Date

_____ __/_____/ ____
Domestic Partner Name & Employee Number- Print — Date of Birth

_____ __//____ _____
Domestic Partner - Signature — Date

Please carefully review the supporting documents to ensure that they are complete and that they meet the requirements of the plan. Be sure to print the Employee's Name and Employee Number on each page that is submitted. Failure to properly complete the required documentation may result in a delay or denial of coverage for your Domestic Partner.