Franklin County Cooperative
Health Improvement Program

Affidavit of Domestic Partnership

This form is to be completed when applying for benefits for your eligible domestic partner. Please return this completed form along with the required documents to the Franklin County Benefits & Wellness Office.*

We,_____ and _____
Franklin County Employee Name (Print) Domestic Partner Name (Print)

Certify that ALL of the following are true:

1. We share a permanent residence (unless residing in different cities, states, or countries on a temporary basis).
2. We are each other's sole domestic partner, have been in a relationship of domestic partnership for at least the past six (6) months, and intend to remain in this relationship indefinitely.
3. Neither of us are married to or legally separated from another person under either statutory or common law.
4. We share responsibility for each other's common welfare.
5. We are at least eighteen (18) years of age and mentally competent to consent to this contract.
6. We are not related by blood to a degree of closeness that would prohibit marriage in the state in which we legally reside.
7. We are currently and have been for **at least the past 6 months financially interdependent** upon each other in accordance with the plan requirements outlined by Franklin County Cooperative Health Improvement Program the ("Cooperative"). Financial interdependency must be supported by **three** of the following. Documents submitted to support financial interdependency (i.e. joint deed or lease, beneficiary designation form, etc.) must illustrate financial interdependency for at least six (6) months. Please check the documents being provided:
   - ❑ Joint ownership of real estate property or joint tenancy on a residential lease
   - ❑ Joint ownership of an automobile
   - ❑ Joint bank or credit account
   - ❑ Joint liabilities, (e.g. credit cards or loans)
   - ❑ A will designating the domestic partner as primary beneficiary
   - ❑ A retirement plan or life insurance policy beneficiary designation form designating the domestic partner as primary beneficiary
   - ❑ A durable power of attorney signed to the effect that we have granted powers to one another
8. I agree to file an Affidavit of Termination of Domestic Partnership with the Franklin County Benefits & Wellness Office and mail a signed copy to my previous domestic partner **within 30 days** of either of the following events:
   - There is any change in the circumstances attested to in this Affidavit that would make my domestic partner ineligible for benefits under the County; or
   - We terminate our domestic partnership.
9. I understand that another Affidavit of Domestic Partnership cannot be filed for a least six (6) months from the date that an Affidavit of Termination of Domestic Partnership is filed with the Franklin County Benefits & Wellness Office.

Please return form(s) to:
Franklin County Benefits & Wellness Office
373 S High Street, 25th Floor
Columbus, Ohio 43215
(T) 614.525.5750
(F) 614.525.5515
(E) Benefits@franklincountyohio.gov
(W) http://BeWell.franklincountyohio.gov

- We provide this information to be used by the Cooperative for the purpose of determining our eligibility for benefits and for the administration of these benefits; we understand that the Cooperative will take reasonable steps to limit access to this information. We understand this form may be supplied to my agency's Human Resources Department.
- We understand that, by signing this Affidavit and as a result of Franklin County providing benefits to us, there may be legal and tax implications; therefore, we have been advised to consult with a legal/tax advisor regarding these implications.
- We certify that the information provided in all parts of this Affidavit is true, accurate, and complete. We understand that a false declaration of domestic partnership, material omission of information on this Affidavit, or failure to timely inform the Franklin County Benefits & Wellness Office of the termination of a domestic partnership is considered fraud and may result in disciplinary action of an employee up to and including termination of benefits and/or employment. We also agree that the Cooperative may recover damages for all losses (including paid claims and premiums costs) and reasonable attorney's fees incurred to recover such damages.

This form must be signed by both the employee and the domestic partner.

Signature of Employee	Date of Birth	Date
Signature of Domestic Partner	Date of Birth	Date

Employee's Social Security Number (required):_____ Agency:_____

This form must be notarized.

Sworn or affirmed to and subscribed before me this_____day of_____, 20____by

_____ and by _____.
Name of employee Name of domestic partner

Signature of Notary Public	Date

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