Office of HUMAN RESOURCES — THE OHIO STATE UNIVERSITY

AFFIDAVIT OF SAME-SEX DOMESTIC PARTNERSHIP

(For Health Care and Life Insurance Coverages)

This form is to be completed when applying for health and/or life benefits for your eligible same-sex domestic partner. Return the completed affidavit along with the applicable benefit election form(s) to the Office of Human Resources.

I, _____, and _____
Faculty/Staff Member (Print) — Same-Sex Domestic Partner (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 same-sex domestic partner, have been in this relationship for at least six (6) months, and intend to remain in this relationship indefinitely.
3. We are of the same sex as each other and neither of us is currently married to or legally separated from another person under either statutory or common law.
4. We are responsible 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 financially **interdependent** on each other in accordance with the plan requirements outlined by Ohio State. Financial interdependency may be demonstrated by the existence of **three (3)** of the following *(Please check below the documents that can and will be provided to the Office of Human Resources, if requested, to verify same-sex domestic partnership):*

   - ☐ 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 same-sex domestic partner as primary beneficiary
   - ☐ A retirement plan or life insurance policy beneficiary designation form designating the same-sex domestic partner as primary beneficiary
   - ☐ A durable power of attorney signed to the effect that we have granted powers to one another

- I agree to file an *Affidavit of Termination of Same-Sex Domestic Partnership* with the Office of Human Resources and mail a signed copy to my previous same-sex domestic partner **within 31 days** of either of the following events:
  - There is any change in the circumstances attested to in this *Affidavit* that would make my same-sex domestic partner ineligible for coverage under the terms of the university's health and life insurance plans; or
  - We terminate our same-sex domestic partnership.
- I understand that another *Affidavit of Same-Sex Domestic Partnership* cannot be filed for at least six (6) months from the date that an *Affidavit of Termination of Same-Sex Domestic Partnership* is filed with the Office of Human Resources.
- We provide this information to be used by the university for the purpose of determining our eligibility for benefits and for the administration of these benefits; we understand that the university will take reasonable steps to limit access to this information.
- We understand that, by signing this *Affidavit* and as a result of Ohio State 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 same-sex domestic partnership, material omission of information on this *Affidavit*, or failure to timely inform Ohio State of the termination of a same-sex 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 Ohio State may recover damages for all losses (including paid claims and premium costs) and reasonable attorneys' fees incurred to recover such damages.

Signature of Faculty/Staff Member	Date of Birth	Date
Signature of Same-Sex Domestic Partner	Date of Birth	Date

Sworn to and subscribed in my presence this _____ (Date) day of _____ (Month), _____ (Year).

(Seal)

_____
Signature of Notary Public

If you have questions, contact the Office of Human Resources Customer Service Center at service@hr.osu.edu, **http://hr.osu.edu**, (614) 292-1050, 1-800-678-6010, or fax: (614) 292-6235.

Return completed form to:
Office of Human Resources, Benefits Processing/SSDP, 1590 North High Street, Suite 300, Columbus, OH 43201-1189

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