

AFFIDAVIT OF DEPENDENT DOMESTIC PARTNERSHIP

PERS Retiree Name

Social Security Number

Section I. Affirmation of Dependent Domestic Partnership

We, the undersigned, declare that we are domestic partners, and we:

- a. Share a close personal relationship and are responsible for each other's common welfare;
- b. Are each other's sole dependent domestic partner;
- c. Are not married to anyone, nor have had another domestic partner within the previous 12 months;
- d. Are not related by blood closer than would bar marriage in the State of Oregon;
- e. Have jointly shared the same regular and permanent residence for at least (12) months immediately preceding the date of this Affidavit with the intent to continue doing so indefinitely;
- f. Will provide a copy of PERS retiree's most recent federal tax return for verification of dependent status as required by IRC Section 152.

We also declare the following to be true:

- (1) The PERS retiree, who meets the general eligibility of ORS 238.410 for enrollment into the PERS Health Insurance Program and who is one of the parties of this domestic partnership, is providing over one half of the financial support for his/her dependent domestic partner; and
- (2) Has claimed his/her dependent domestic partner on his/her most recent federal tax return.

Section II.

DECLARATION OF MEMBER

I understand that my dependent domestic partner is eligible for enrollment at:

- (1) The time of my retirement;
- (2) Within 90 days of Medicare eligibility;
- (3) Or within 30 days of meeting the criteria listed in Section One.

I understand that any children of my dependent domestic partner are not eligible for enrollment unless they meet the criteria as an eligible dependent defined in OAR 459-035-0020(3) and the dependency requirement under Section I (1) and (2) of this Affidavit.

In the event of my death, or the termination of this agreement, my covered dependent domestic partner may elect COBRA continuation coverage on a self-pay basis subject to COBRA regulations.

I agree to notify the PERS Health Insurance Program within (30) days of any change to circumstances attested to in this Affidavit.

We understand willful falsification of information contained in this Affidavit will result in termination of enrollment pursuant to this agreement in the PERS Health Insurance Program.

Signature of PERS Retiree

Signature of Dependent Domestic Partner

Print Name

Print Name

Date of Signature

Date of Signature