

AFFIDAVIT OF DOMESTIC PARTNERSHIP

Send completed form to Employee Hub (EmployeeHub@thgrp.com)

Employee Information			
Employee Legal Name (First, Middle Initial, Last):		Social Security Number:	
Domestic Partner Information			
Domestic Partner Legal Name (First, Middle Initial, Last):		Social Security Number:	
Mailing Address:	City:	State:	Zip Code:
Tax Dependent Information			
Is the domestic partner or domestic partner's child(ren) a qualified tax dependent as defined by the IRS?		Yes* or No	
*If Yes, please also complete the <i>Health Plan Certification of Dependent Status for Federal Income Tax Purposes Form</i> .			
Affidavit			
<p>For the domestic partner and domestic partner's child(ren) to be covered under <i>The Heritage Health Care Plan</i>, we, the undersigned, declare that the following characteristics are true:</p> <ul style="list-style-type: none"> • We have lived together for at least six consecutive months; • We share financial responsibilities; • We are not so closely related by blood that legal marriage would otherwise be prohibited under state law; • We are at least 18 years of age; • We are mentally competent; • We intend that the domestic partnership be of unlimited duration; • We are not legally married to anyone or engaged in another domestic partnership; • We have registered as domestic partners or will register our domestic partnership if that option becomes available under the law; and • We agree to inform the company if the domestic partnership terminates. <p>We certify that the foregoing information is true and correct and understand that a false declaration of the domestic partnership or failure to file a timely notice of <i>Termination of a Domestic Partnership form</i> with your HR Representative will result in termination of health benefits for the domestic partner and domestic partner's child(ren) retroactive to the time the criteria ceased to be true.</p> <p>Furthermore, we agree that in the event of a false declaration, or failure to file a <i>Termination of a Domestic Partnership form</i> with the company, the company may recover damages from either or both of us for all costs and expenses incurred by the company because of that false declaration, including, without being limited to, attorneys' fees incurred by the company to recover such damages.</p>			
Employee Signature:		Date:	
Domestic Partner Signature:		Date:	



BENEFITS + WELLNESS