AFFIDAVIT OF DOMESTIC PARTNERSHIP

Clackamas County

Complete the fillable fields in reading order. Enter dates as MM/DD/YYYY. Section E applies only when certifying federal tax-dependent status.

Section A: Employee Information

Last Name, First Name	Employee ID
Department	**Work Phone**

Mailing Address, City, State, ZIP

Section B: Domestic Partner Information

Last Name, First Name	Date of Birth	Gender

Section C: Domestic Partner Requirements

I, _____ certify that _____ and I are, and
print name of employee — print name of domestic partner

have been, each other's partner in a domestic partnership as defined below.

For the purposes of this affidavit, a "domestic partnership" is one consisting of two persons in which the following applies:

1. Both are at least 18 years of age;
2. Are responsible for each other's welfare and are each other's sole domestic partner;
3. Are not married to anyone and neither has not had a spouse or another domestic partner within the prior six months (if previously married, the six month period starts on the final date of divorce);
4. Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
5. Have jointly shared the same regular and permanent residence for at least six months; and
6. Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses for maintaining a household (financial information must be provided if requested).

Section D: Enrollment and Eligibility Criteria

1. I understand that my domestic partner is eligible for enrollment only at the time this affidavit is notarized.
2. I understand a completed affidavit must be included with enrollment of my domestic partner. If enrollment of my domestic partner is due to a loss of their own group health coverage, enrollment in the County's plan must be completed within 60 days from date their coverage terminated.
3. I understand that children of my domestic partner are eligible if they are under age 26, reside in my home and/or there is a court order to provide insurance coverage.
4. I understand that coverage for my domestic partner shall terminate upon a change in circumstance attested to in Section C of this affidavit.
5. I agree to provide written notice to the Clackamas County Benefits Team if there is any change of circumstances attested to in the affidavit within 60 days of the change by filing a "Termination of Domestic Partner Benefits."

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Section E: Dependent Domestic Partner Status (if applicable)

Use this form if you are an active employee and want to certify that your Domestic Partner or Domestic Partner's children qualify as current federal tax dependents for the purpose of pre-tax health benefits.

I declare under penalty of perjury under the laws of the State of Oregon that the statements below are true and correct:

1. _____ is my domestic partner on the date of this affidavit.
   name of domestic partner
2. I have read the notice titled "Tax Treatment of Benefit Coverage Provided for Domestic Partners" on page 4 and understand the requirements for qualifying an individual as my federal tax dependent.
3. The individual named above, and if applicable, the individual's child(ren), meets one of the following federal tax dependent status options:

Federal tax dependent status - select one only

- ◯ Qualifies as my federal tax dependent(s) in the current tax year and I expect they will continue to qualify as my federal tax dependent(s) next year and in future tax years.
- ◯ Does not qualify as my federal tax dependent(s) in the current tax year but I expect they will continue to qualify as my federal tax dependent(s) next year and in future tax years.
- ◯ Does not qualify as my federal tax dependent(s) in the current tax year, and I do not expect they will qualify as my federal tax dependent(s) next year or in future tax years.

4. I agree to notify the Clackamas County Benefits Team in writing as soon as there is any change in the above person's status as my tax dependent.
5. I understand that, based on the statements in this affidavit, the individual named above, and if applicable, the individual's child(ren), will be considered my tax dependent(s) by Clackamas County for all federal income and employment tax purposes.
6. I agree to reimburse and indemnify Clackamas County for any taxes, penalties, interest, or other losses (including reasonable attorneys' fees) incurred as a result of the County's reliance on this affidavit if any statement is untrue or if I fail to provide the notice required in item 4.

Name of Domestic Partner	Date of Birth

List each child of the Domestic Partner to be certified as a tax dependent:		
Name of Domestic Partner's Child 1	**Date of Birth**	**Gender**
Name of Domestic Partner's Child 2	**Date of Birth**	**Gender**
Name of Domestic Partner's Child 3	**Date of Birth**	**Gender**

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Section F: Authorization

1. We understand that the information contained in the affidavit will be held confidential and will be subject to disclosure only upon our express written authorization or as required by law.
2. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of a willful falsification of information contained in this affidavit.
3. We understand that under federal income tax law, payments for health coverage of a domestic partner may not be eligible for treatment under Clackamas County's Section 125 Flexible Benefits Plan. We also understand that health coverage of the non-employee domestic partner could result in additional imputed taxable income to the employee, with possible withholding for payroll taxes including income and social security taxes unless the domestic partner qualifies as a federal tax dependent under Internal Revenue Code Section 152(a).
4. We understand that, in addition to the eligibility requirements of Clackamas County for domestic partner coverage, there are terms and conditions of coverage set forth in the Group Insurance Contract of each health care plan offered through the County to which we agree to be bound.
5. We understand willful falsification of information contained in this affidavit may result in the termination of our enrollment, which would be immediate and without prior notice, by the health plan we selected for coverage.
6. We also certify under penalty of perjury under the laws of the State of Oregon that the foregoing is true and accurate to the best of our knowledge.

Signature of Employee	**Date**
Signature of Domestic Partner	**Date**

Notary Acknowledgment

STATE OF OREGON

COUNTY OF

On (today's date)

Before me, personally appeared (print name of employee)

and (print name of domestic partner)

Identity verification method - select one only

◯ Personally known to me ◯ Proved to me through satisfactory evidence

to be the persons whose names are subscribed to the above instrument and acknowledged to me that each person executed the same in their authorized capacity and that by their signature on the instrument is one of the persons who executed the instrument.

Notarial Signature and Seal of Notary

My Commission Expires

Tax Treatment of Benefit Coverage Provided for Domestic Partners

Eligibility for Domestic Partner

Group health coverage, including medical and dental benefits, is available for domestic partners, and if applicable, their child(ren), of eligible employees. Refer to the applicable summary plan description and enrollment materials for a definition of domestic partner and the procedure you must follow to enroll your domestic partner.

Tax Consequences of Domestic Partner Coverage

Under federal tax law, if your (non-spouse) domestic partner does not qualify as your tax dependent, as defined below, then the portion of premiums the County pays for the coverage of your domestic partner will be included in your gross income and will be subject to federal tax withholding and employment taxes, and will be reported on your W-2 form. You will also be unable to claim expenses for the domestic partner under the Health Care Flexible Spending Account.

When a Domestic Partner Is a Tax Dependent

If your domestic partner, and if applicable, their child(ren), qualifies as your tax dependent(s), then no portion of the premiums paid by the County will be included in your income or be subject to federal withholding or employment taxes.

Who Is a Tax Dependent?

Your domestic partner may qualify as your tax dependent under Internal Revenue Code Section 152(a) if all the following apply:

1. They lived with you for the entire calendar year as a member of the household, and
2. Their gross income for the year was less than $5,300, and
3. You provided more than half of their total support during the year.

Note that it is not necessary for you to be able to claim an exemption for your domestic partner on your Form 1040. If your tax year is other than the calendar year, use that year instead.

The IRS may also treat your domestic partner as a tax dependent if they meet the above two requirements for the first portion of the year, you then marry, and they remain your legal spouse for the remainder of the year.

Determine Support

To determine whether you provide more than half your domestic partner’s total support, you must compare the amount of support you provide with the amount of support your domestic partner receives from all sources, including social security, welfare payments, the support you provide and the support your domestic partner supplies for themselves. Support includes food, shelter, clothing, medical and dental care, education, etc. If you believe you might provide more than half of your partner’s support, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information) before you complete the Affidavit described below.

Filing a Dependent Domestic Partner Status

If your domestic partner, and if applicable, their child(ren), qualifies as your tax dependent(s), you may avoid taxation of employer-paid premiums by completing Section E on page 2.

Because dependent status is based on facts known only to you, the County cannot determine your tax-dependent eligibility on your behalf.

You must complete and sign the affidavit in the presence of a Notary Public.