AFFIDAVIT OF DOMESTIC PARTNERSHIP

MEDICAL CARE EXPENSE PLAN, DENTAL PLAN AND VISION PLAN

Note: The definition of "Domestic Partner" for purposes of this Affidavit shall be two individuals, of the same sex, who live together with an exclusive mutual commitment in which the Domestic Partner agrees to be jointly responsible for each other's common welfare and to share financial obligations.

SECTION ONE

I, and _____ are Domestic Partners, and we:

(Name of Domestic Partner)

1) are each eighteen (18) years of age or older;
2) share a close personal relationship and are responsible for each other's common welfare;
3) are each other's sole Domestic Partner;
4) are not married to another person;
5) are not related by blood closer than would bar marriage in the State of Colorado;
6) share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
7) are jointly financially responsible for "basic living expenses" defined as the cost of basic food, shelter and any other expenses of a Domestic Partner which are paid at least in part by a program or benefit for which the partner qualified because of the domestic partnership. (Note: Domestic Partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.);
8) were mentally competent to consent to contract when our domestic partnership began.

SECTION TWO

1. I understand that my Domestic Partner is eligible for enrollment during open enrollment periods, at the time of my hire or within 30 days of becoming a newly eligible dependent.
2. I understand that this Affidavit shall be terminated upon the death of my Domestic Partner or by a change in circumstance attested to in this Affidavit.
3. I agree to provide written notice to the Human Resources if there is any change of circumstances attested to in this Affidavit within 30 days of the change by filing a Statement of Termination of Domestic Partnership.

SECTION THREE

1. We understand that the information contained in the Affidavit will be held confidential and will be subject to disclosure only upon 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 of Domestic Partnership.
3. We understand that a domestic partnership may create certain legal and tax rights, duties, and/or liabilities, and we are advised to seek individual legal and tax advice.
4. We understand that City and County of Broomfield provided benefits for the Domestic Partner and Domestic Partner's eligible dependents shall be considered taxable imputed income to the City and County of Broomfield employee unless such Domestic Partner qualifies as a dependent under § 152 of the Internal Revenue Code.

5. We understand that any portion of the employee-paid premium for medical, dental and vision that pays for coverage of the Domestic Partner and Domestic Partner's eligible dependents are not eligible pre-tax contributions unless such Domestic Partner qualifies as a dependent under § 152 of the Internal Revenue Code.
6. We understand that non-reimbursable health care expenses of a Domestic Partner andD omestic Partner's eligible dependents are not eligible pre-tax expenses and cannot be reimbursed out of the employee's § 125 flexible spending account. This does not apply to a Domestic Partner or Domestic Partner's eligible dependents if the Domestic Partner qualifies as a dependent under § 152 of the Internal Revenue Code.
7. We understand that, in addition to the eligibility requirements of **City and County ofBroomfield** for Domestic Partner coverage, there are terms and conditions of coverage set forth in the Evidence of Coverage of each medical care plan offered through **City and County of Broomfield** to which we agree to be bound.
8. We understand that willful falsification of information contained in this Affidavit may result in our termination of enrollment by the health, dental and/or vision care plan that we select for coverage.
9. We also certify under penalty of perjury under the laws of the State of Colorado that the foregoing is true and accurate to the best of our knowledge.

_____ _____

Signature of Employee Date

_____ _____

Signature of Domestic Partner Date

_____

Street Address

_____

City, State, Zip Code

County of Broomfield

State of Colorado

SUBSCRIBED AND SWORN before me this _____ day of _____, 20___

_____

Notary Public

My Commission Expires _____