

UNITED FURNITURE WORKERS *Insurance Fund*

Affirmation of Domestic Partnership

- THIS DOCUMENT MUST BE NOTARIZED -

I. General Information

Eligible Employee Name _____

Eligible Employee Social Security # _____ - _____ - _____

Employer _____

Name of Domestic Partner _____ Gender [] Male [] Female

Date of Birth _____ Domestic Partner Social Security # _____ - _____ - _____

Date of Commencement of Domestic Partnership: _____

*A Domestic Partnership commences on the first day on which such relationship satisfies each and every one of the criteria listed in Section II below.

Address of Eligible Employee and Domestic Partner:

Street _____

City _____ State _____ Zip Code _____

Telephone Number of Eligible Employee and Domestic Partner:

(_____) _____ - _____

II. Affirmation of Domestic Partnership

The undersigned Eligible Employee and Domestic Partner individually and collectively attest, in affirmation of their status as Domestic Partners, that their relationship satisfies **each and every** one of the following criteria:

- (a) Eligible Employee and Domestic Partner are each at least eighteen (18) years of age;
- (b) Eligible Employee and Domestic Partner share the same principal residence, and intend to continuing doing so;
- (c) Eligible Employee and Domestic Partner are engaged in a financially-interdependent relationship, and intend to remain so in the future;
- (d) Eligible Employee and Domestic Partner are, and for a period of at least six (6) months, have been, engaged in a committed, exclusive relationship of mutual caring and support, and intend to remain so in the future;
- (e) Eligible Employee and Domestic Partner are jointly responsible for each other's common welfare and basic needs, and intend to remain so in the future;
- (f) Neither Eligible Employee nor Domestic Partner is legally married;
- (g) Neither Eligible Employee nor Domestic Partner is engaged in a domestic partnership with any person other than each other; and

(h) Eligible Employee and Domestic Partner are not related by blood or marriage to a degree of closeness that would prohibit legal marriage in the state in which Eligible Employee and Domestic Partner reside.

Eligible Employee and Domestic Partner, individually, and in their collective capacity as a Domestic Partnership, declare that all of the above statements are true and correct and, to the best of Eligible Employee's and Domestic Partner's knowledge and belief, contain no material omissions of fact or inaccuracies.

Signature of Eligible Employee _____ Date _____

Signature of Domestic Partner _____ Date _____

Note: Eligible Employee and Domestic Partner may be required by the Fund to provide documentary proof of Domestic Partnership status, including, but not limited to, evidence of common ownership and/or co-habitation of real property, evidence of common ownership of an automobile, evidence of a joint bank account or credit card, and/or evidence of designations as each other's beneficiaries for insurance or retirement benefits or under a will or other testamentary instrument.

III. Notification of Change In or Termination of Domestic Partnership

Eligible Employee understands that, if the Domestic Partnership affirmed in this document ceases to satisfy *one (1) or more* of the criteria listed in Section II above, or otherwise ceases to exist (hereinafter referred to as the occurrence of a "Termination Event"), Eligible Employee is required to notify the Fund of such Termination Event within thirty-one (31) days after its occurrence, and must complete and submit to the Fund a Request for Change in Status form supplied by the Fund. Eligible Employee and Domestic Partner understand that if Eligible Employee fails to notify the Fund of a Termination Event within the allotted thirty-one-day period, Eligible Employee and Domestic Partner will be jointly and severally responsible for reimbursing the Fund for any benefits provided on behalf of any individual whose coverage should have terminated as a result of the Termination Event, in addition to any costs, fees, and other expenses associated therewith, retroactive to the date of the Termination Event.

Signature of Eligible Employee _____ Date _____

Signature of Domestic Partner _____ Date _____

IV. Notarization

Sworn to before me this _____ day of _____ 20 _____

Notary Public

*Affix Notary Stamp Above