City of Hope

AFFIDAVIT OF SPOUSAL EQUIVALENCY

I, _____, certify that:
(Name of Employee - Print)

1. I, _____, and _____ reside
(Name of Employee - Print) (Name of Spousal Equivalent)

together at the following address:

_____
(Address, City, State, Zip)

2. We have resided together at the address listed above for at least six (6) consecutive months prior to the date of this affidavit and intend to reside together permanently. We certify that two or more of the following exist as evidence of joint responsibility for basic financial obligations: (Please check off those items that apply.)

___ joint mortgage or lease
___ designation of the Domestic Partner as durable power of attorney or health care proxy
___ joint wills or designation of the Domestic Partner as executor and/or primary beneficiary
___ joint bank account, joint credit cards or evidence of other joint financial responsibility
___ designation of the Domestic Partner as beneficiary for life insurance or retirement benefits

3. We are not married to anyone and are the sole partners of each other.

4. We are at least eighteen (18) years of age or older.

5. We are not related by blood closer than would bar marriage in our state of residence and are mentally competent to consent to contract.

6. We are in a committed and mutually exclusive relationship, jointly responsible for the other's welfare and financial obligations.

7. We understand that spousal equivalents are subject to the same rules, guidelines and policy provisions governing all other employees who are covered by or apply for insurance coverage.

8. We agree to notify the Employer in writing if there is any change of circumstances attested to in this Affidavit within thirty (30) days of such change.

9. Upon termination of this spousal equivalent relationship, a Notice of Termination of Spousal Equivalency shall be filed with Employer within 30 days. Such termination statement shall affirm, under a penalty of perjury, that the spousal equivalent relationship is terminated and that a copy of the termination statement has been mailed to the other partner.

10. After such termination, Employee understands that another Affidavit of Spousal Equivalency cannot be filed until six (6) months after a statement of termination of the previous spousal equivalent relationship had been filed with Employer.

11. We understand that any persons/employer/company who suffer any loss because of false statement contained in an Affidavit of Spousal Equivalency may bring a civil action against us to recover their losses including reasonable attorney's fees.

12. We understand that health insurance coverage is subject to all terms and conditions required by the group policy of the health insurance plan.

13. We understand that current State and Federal continuation or conversion coverage laws may not apply to spousal equivalents. Continuation coverage laws provide the right to pay for a temporary extension of health insurance if coverage would terminate due to termination of employment, reduction in hours, death of spouse, and/or divorce.

14. We understand that Employer reserves the right to make changes in health plan benefits, premiums and eligibility requirements, and to make a determination that this spousal equivalency relationship conforms to the provisions of this Affidavit.

15. We understand and affirm, under penalty of perjury and employee disciplinary action which may result in loss of employment, that the information provided on this Affidavit is accurate and complete. We understand and agree that any omissions or incorrect statements knowingly made on this Affidavit may invalidate our insurance coverage.

16. We have had the opportunity to consult an attorney regarding the filing of this Affidavit. We understand that it may have certain legal consequences, including that, in the event of a termination of the spousal equivalent relationship, the Affidavit may lead a court to treat the relationship as the equivalent of marriage for the purpose of establishing and dividing community property, or for ordering payment of support.

EMPLOYEE

_____ _____

Date Signature of Employee

_____ _____

Date of Birth Social Security Number

SPOUSAL EQUIVALENT

_____	_____
Date	Signature of Partner
_____	_____
Date of Birth	Social Security Number

NOTARY (required)

Subscribed and sworn to before me by said _____ this

_____ day of _____, 20___.

_____
Notary Public

My commission expires _____

(10/00)