HONORHEALTH®

DOMESTIC PARTNER ENROLLMENT FORM

IMPORTANT: TAX IMPLICATIONS APPLY

Employee Name:	Employee ID #:
Daytime phone #:	E-mail:

Domestic partner information:

Name:	Date of birth:
Social Security Number:	Male ☐ Female ☐
Daytime phone #:	E-mail:
***** Coverage will begin the day after this enrollment form and all proper documents are received:***	

Coverage options:

☐ Medical ☐ Dental ☐ Vision	☐ Domestic Partner Life Insurance ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Note: Please see Page 3 for Domestic Partner taxable amounts.

Affidavit of Domestic Partnership

We, the above named parties, hereby declare that we are domestic partners and further declare that we meet the all of the following criteria of domestic partnership:

1. We are both at least 18 years of age.
2. We have lived with each other continuously for at least one year, and we will continue to live together throughout the entire period of benefit coverage.
3. We have a serious, committed and exclusive relationship with each other and intend for the relationship to be permanent.
4. Neither of us is legally married to any other individual, and if previously married, a legal divorce or annulment has been obtained, or the former spouse is deceased, and, neither of us is considered a domestic partner of anyone else.
5. We are not related to each other in any way that would bar marriage under state law if we otherwise satisfied all other applicable marriage requirements.
6. We are both mentally competent to enter into a contract according to state law.
7. We are not in this relationship solely for the purpose of obtaining benefits.
8. We are financially interdependent such that we are jointly responsible for the common welfare and financial obligations of the household, or the non-employee domestic partner is chiefly dependent upon the employee for care and financial assistance.

We understand that:

1. No employee who is eligible for HonorHealth medical, dental or vision benefits can be covered as the domestic partner of another employee who is also eligible for those benefits.

2. **We are aware of the potential tax implications of obtaining medical and dental benefits for a domestic partner. We acknowledge that adding a domestic partner changes the employee's coverage from single to employee + spouse or**

family, the difference between the amount of the premium HonorHealth pays on your behalf for single coverage and the amount HonorHealth pays on your behalf for employee + spouse coverage will be considered imputed income pursuant to IRS regulations. This means this amount will be added to your gross taxable income and affect your tax liability.

3. If the domestic partnership no longer meets all of the criteria attested to this Affidavit, we must file a Notice of Termination of Domestic Partnership within thirty (30) days of such change with the Employee Benefits Department.

4. If we supply false information on this Affidavit, submit fraudulent benefit claims, or fail to notify HonorHealth of the termination of our domestic partnership, HonorHealth may:
   - Recover any benefits improperly paid.
   - Initiate disciplinary action, which may include termination of the employee's employment. We further understand that any person/employer/company who suffers any loss due to any false statement contained in any document provided as part of this Affidavit, any fraudulent benefit claim, or failure to notify HonorHealth as described above, may bring civil action against either or both of us to recover their losses, including reasonable attorney's fees.

5. The filing of this Affidavit may have other legal and/or financial consequences, including the fact that it may be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for purposes of establishing and diving community property, assigning community debt, and for the payment of support.

6. The Employee Benefits Department requires proof of eligibility before coverage will begin. The Employee Benefits Department will determine the effective date of coverage. The effective date will usually be the first of the month following the collection of all proper documents.

7. The Flexible Spending Account cannot be used to cover a domestic partner or their children's health or dependent care expenses.

8. In the event of termination of the domestic partnership, it is understood that my former domestic partner and applicable dependents will no longer be covered under the medical, dental and/or vision plans. I also understand that no extended benefits, conversion privilege or continuation of coverage will be available to my former domestic partner for some voluntary benefits after coverage ends.

9. **Documentation of two items as evidence of our joint responsibility and commitment to our domestic partnership must be received and approved by the Employee Benefits Department before coverage will begin. At least one of these two items must be from List A. All documents must be dated back one year prior to enrollment.**

At least one of these two items below must be from List A

List A

- Joint obligation on a loan (including an affidavit by a creditor by a creditor for a personal loan).
- Joint ownership of our shared residence.
- An affidavit by a creditor able to testify to our financial interdependence.
- Designation of one partner as the representative payee for the other's government benefits.
- Joint ownership or holding of investments.
- Joint ownership or lease of a motor vehicle.
- Both listed as responsible parties on the lease of a shared residence.
- Mutually granted authority to make healthcare decisions (e.g., health care power of attorney).
- Mutually granted durable power of attorney.

List B

- Designated as beneficiary under the other's life insurance policy, retirement benefits account or will or executor of each other's will.
- Joint bank account.
- Joint credit or charge card(s).
- Status as authorized signatory on the partner's bank account, credit card or charge card.
- Other proof of economic Interdependence (e.g., shared household expenses such as electric, city, water or phone bills).

2024 Domestic Partner Taxable Amounts

Coordinated Care Plan:	$193.00	Dental Base Plan:	$8.00	EDS Plan:	$2.00
Standard Plan:	$237.00	Dental Buy-Up:	$5.00		
High Deductible Plan:	$218.00	Dental Enhanced:	$2.00		

Acknowledgements:

1. We certify that any and all representations that we have made and information that we have provided as part of this Affidavit as evidence of our domestic partnership are true and accurate and that any documents provided upon request are authentic.

2. We agree to indemnify, jointly and severally, HonorHealth, for any expenses or liabilities they incur as a result of any misrepresentations or inaccuracies, whether made knowingly or unknowingly, in this Affidavit or in any of the information concerning our domestic partnership provided with this Affidavit.

3. We have provided the information in this Affidavit for the sole use by HonorHealth for the sole purpose of determining our eligibility for domestic partner benefits. If we do not provide the requested information, we understand we will not be eligible for domestic partner benefits. We understand this Affidavit constitutes private information and will not be disclosed to anyone outside the Employee Benefits Department or the appropriate insurance company except as authorized or required by law.

4. We understand that it is in our best interest to consult with an attorney regarding the legal and/or tax consequences of signing this Affidavit.

5. We affirm under penalties of perjury, that the assertions in this Affidavit are true and correct to the best of our knowledge and belief.

Employee signature_____ Date_____

Domestic partner signature_____ Date_____

Notary Public

Sworn and subscribed before me this _____ day of_____, 20_____.

Signature of Notary Public _____

My commission expires: _____

Return completed form and required documents to:

Employee Benefits
Fax: 480-882-5802 or
E-mail: employee.benefits@honorhealth.com

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