AFFIDAVIT OF DOMESTIC PARTNERSHIP

I. DECLARATION

_____ and _____
Employee (print) Domestic Partner (print)

Certify that we are domestic partners in accordance with the criteria identified in Section II (Status) and are eligible for benefit coverage as domestic partners under the coverage provided by the City of Dallas.

II. STATUS

The employee and domestic partner represent that they meet each of the identified criteria and agree to provide evidence as requested attesting that the following eligibility requirements are met:

1. We are the same gender and;

2. We reside together in the same permanent residence and have lived in a spouse-like relationship for at least six (6) consecutive months and;

3. We are both at least 18 years of age and are not related by blood and;

4. We are not legally married or the common-law spouse or Domestic Partner of any other person;

III. CHANGE IN DOMESTIC PARTNERSHIP

We agree to notify our employer within thirty (30) days if there is any change in our status as domestic partners, including the information attested to in this Affidavit which would make us no longer eligible for employee or domestic partner coverage or where we no longer meet one or more of the requirements of Section II (Status).

IV. ACKNOWLEDGEMENTS

We understand and agree that if the City of Dallas suffers any loss due to any false statement contained in this Affidavit, it may bring a civil action against either or both of us to recover its losses, including reasonable attorney fees. We understand and agree that the City of Dallas may (1) terminate the coverage of the employee or domestic partner if that individual does not meet the eligibility requirements of the coverage provided by the City of Dallas or

the criteria identified in this Affidavit or (2) rescind our health and/or pharmacy care coverage back to the effective date of our coverage if the City of Dallas concludes one or both of us made fraudulent representations in this Affidavit.

We have provided the information in this Affidavit for use by our employer and health insurance carrier for the purpose of determining our eligibility of domestic partner coverage.

We affirm, under penalty of perjury, that the representations made in this Affidavit are true to the best of our knowledge.

_____ _____

Employee Signature Date

Employee Address:

_____

_____

_____

_____ _____

Domestic Partner Signature Date

Domestic Partner Address:

_____

_____

_____