



PO Box 12430
Albany, NY 12212-2430
(877) RN BENEFITS
FAX (518) 869-2317
www.rnbenefits.org

Affidavit and
Annual Certification
of Domestic Partnership

I, _____ (name), being duly sworn,
depose and says: my Social Security number is _____.
I declare that _____ (name)
_____ (date of birth) _____ (Social Security number)

is my same-sex domestic partner, meaning that we do
now and have lived in a committed family relationship
for at least six months, and we can submit proof of
cohabitation and that we:

- Are each other's sole same-sex domestic partner
and intend to continue living together as such in the
future.
• Are not legally allowed to marry under current laws
of the state in the State of New York.
• Are not legally married to anyone.
• Are both age 18 or older.
• Are not parent, child, sibling, grandparent or any
other blood relation which would bar marriage under
the laws of the State of New York.
• Share joint responsibility for one another's common
welfare and basic needs, evidenced by submitted
proof of at least two of the following (check those
that you will submit as proof):
— Ownership of a joint bank account.
— Ownership of a joint credit card.
— Evidence of a joint obligation on a loan.
— A joint mortgage or lease.
— Joint ownership of a residence.
— Evidence of a common household (household
expenses such as utility bills, telephone bills,
joint public assistance budget, etc.).
— Joint ownership of a motor vehicle.
— Execution of wills naming each other as executor
and/or beneficiary.
— Granting each other powers of attorney.
— Designation by one or the other as beneficiary
under a retirement benefits account.
— Evidence of other joint responsibility.

1. I understand that, subject to eligibility provisions
of the plan, I have the opportunity to cover my
same-sex domestic partner under my benefit plans
according to the same terms and with the same
privileges and restrictions that apply to an eligible
spouse to the extent permissible under federal and
state law.
2. I understand that any benefits I elect for my same-
sex domestic partner using this affidavit will remain
in effect until the earlier of:
a. Termination of New York State Nurses Associa-
tion Benefits Fund coverage.
b. Termination of the same-sex domestic partner-
ship.
c. Death of my same-sex domestic partner.
3. I understand that my same-sex domestic partnership
benefits end if any of the eligibility requirements
listed above are no longer satisfied. I understand
that if my relationship with the person named in
this affidavit ends while he or she is covered under
my benefit plan, I/we must notify the Fund Office
within 30 days of the relationship ending and must
sign a Termination of Domestic Partnership form
supplied by that office.
4. I understand that under the current tax law, my
employer may be required by the IRS to report the
value of their contribution toward health insurance
for the same-sex domestic partner and/or any of
his/her dependent children as part of my taxable
income.
5. I understand that I am legally responsible for any
expenses related to the medical benefits I elect for
my same-sex domestic partner.

Please complete both sides of this form and return it to the NYSNA Benefits Fund.

6. I understand that any entities or person, who suffers any loss because of any false statements contained in this affidavit, may bring a civil action suit against me to recover their respective losses, including reasonable attorney's fees. We also understand that any misrepresentation in connection herewith may result in termination of any benefits that may be extended to my same-sex domestic partner based on this affidavit. I declare under penalty of perjury under the laws of the State of New York that the facts contained herein, on any related documentation, and on any New York State Nurses Association Benefits Fund enrollment forms are true and correct.

7. My same-sex domestic partner is currently my dependent as defined by section 152 of the Internal Revenue Code.
 Yes No
8. My same-sex domestic partner's dependent child(ren) is/are currently dependent(s) as defined by section 152 of the Internal Revenue Code.
 Yes No
9. I agree to notify the Fund Office in writing of any change of status in 7 or 8 above.

Warning: Any person who knowingly and with intent to defraud submits an affidavit containing a materially false or deceptive statement may be subject to criminal penalties.

Employee Name (please print above) _____ Date _____ Social Security number _____

Employee Signature _____

Sworn to before me this _____ day of _____ 200_____

Notary Public _____

Please sign and return this form to the New York State Nurses Association Benefits Fund with your proofs of financial interdependence. You will be notified in writing of approval, or if denied, the reasons for denial.

Fund Office section

Approved

Denied. Reason (s) for denial: _____

Signature of Fund Office representative

Date