

AFFIDAVIT OF MARRIAGE OR DOMESTIC PARTNERSHIP

Washington County, Oregon

Section A – Spouse or Domestic Partner Requirements:

I, (print name of employee) _____, certify that (print name of spouse/domestic partner) _____ and I

Are legally married as of _____(marriage date) in _____(county/state).

Are Domestic Partners legally registered by the State of Oregon as of _____(registration date) in _____(county).

Are Domestic Partners legally registered by the State of Washington as of _____(registration date) in _____(county)
AND would otherwise be eligible for registration under Oregon law but for my residence.

Section B – Enrollment/Eligibility Criteria:

- I understand that my spouse/domestic partner is eligible for enrollment only:
 1. Within 30 days of the date that I become eligible as a new employee;
 2. Within 30 days of the date that my spouse/domestic partner loses coverage under their group health plan;
 3. During Open Enrollment;
 4. Within 30 days of the date that my spouse/domestic partner and I meet the definition of a Spouse/Domestic Partner relationship itemized in Section A.
- I understand a completed affidavit must be included with enrollment of my Spouse/Domestic Partner.
- I understand further that children of my spouse/domestic partner are eligible if they meet the eligibility requirements as detailed under each respective benefit plan.
- I understand that coverage for my spouse/domestic partner shall terminate upon a change in circumstances attested to in Section A of this Affidavit.
- I agree to provide written notice to the Support Services Human Resource Division if there is any change of circumstances attested to in the Affidavit within 31 days of the change by completing a “Statement of Termination of Marriage/Domestic Partnership”.

SECTION C – AUTHORIZATION

- I understand that, under applicable federal and state income tax laws, coverage for the non-employee domestic partner will result in additional imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes).
- I understand that, in addition to the eligibility requirements of Washington County for spouse/domestic partner coverage, there are terms and conditions of coverage set forth in the Group Insurance Contract of each health care or other insurance plan offered through the County to which we agree to be bound.
- I understand that willful falsification of information contained in this Affidavit, or failure to provide notice within 31 days of termination may result in disciplinary action (up to and including termination) civil or criminal liability and in termination of enrollment that would be immediate and without prior notice, by the health plan that I select for coverage.
- I also certify under penalty of perjury under the laws of the State of Oregon that the foregoing is true and accurate to the best of my knowledge.

Eligibility for benefits terminates upon the death of the signing employee’s spouse or domestic partner or by a change in circumstances attested to in this affidavit. The signing employee must notify the Support Services Human Resource Division within 31 days after such death or change by filing a Statement of Termination of Marriage or Domestic Partnership. The employee should consult with Human Resources Division if the employee has any question about the impact of a change in circumstances.

NOTE: *Signing this affidavit may or may not have legal implications affecting relations between domestic partners beyond the extension of medical or dental insurance coverage for which it is intended. If you desire further information concerning the possible legal consequences of signing this form, please consult an attorney.*

Employee’s Signature Date

Received by: (Employer or Division) Date