Domestic Partner Coverage

Nationally, the following plans offer domestic partner coverage:

Medical	Cancer/Critical Illness *(Only offered annually during open enrollment)*
Dental	Medical Bridge *(Only offered annually during open enrollment)*
Vision Plan	Whole Life *(Only offered annually during open enrollment)*
Long Term Care	Accident Plan (*Only offered annual during open enrollment)*
Legal Plan	Dependent/Partner Life

This form is required for employees enrolling a domestic partner who have <u>not</u> registered their domestic partnership with a state or local government.

Declaration of Domestic Partnership

Declaration

We, _____ and _____, each certify and declare that
(print employee name) (print domestic partner name)
we are domestic partners in accordance with the following criteria:

Status

1. We affirm that this domestic partnership began on or about / / .

2. We are each other's sole domestic partners, and we intend to remain so indefinitely.

3. Neither of us is married to or legally separated from anyone else nor have had another domestic partner within the prior twelve consecutive months.

4. We are both at least eighteen (18) years of age and mentally competent.

5. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.

6. We cohabit and reside together in the same residence and intend to do so indefinitely. We have resided in the same household for at least twelve consecutive months.

7. We are engaged to a committed relationship of mutual caring and support and are jointly responsible for our common welfare and living expenses. Our interdependence is demonstrated by providing at least three of the following documents (**please check appropriate items**):

- ☐ Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
- ☐ Proof of primary joint bank accounts or credit account for twelve consecutive months
- ☐ Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will
- ☐ Assignment of a durable property power of attorney or health care power of attorney
- ☐ Utility bills for twelve consecutive months

8. We are not in this relationship solely for the purpose of obtaining benefits coverage.

Dependent Children of Domestic Partner

We understand that dependent children of _____ are eligible for coverage when:
(print domestic partner name)

The dependent child(ren) meets all eligibility requirements of the benefit plan(s).

Change in Domestic Partnership

1. We have an obligation to notify Atkins by filing a Declaration of Termination of Domestic Partnership if there is a any change in our domestic partnership status as attested to in this declaration that would terminate this declaration (e.g., due to death of a partner, a change in the residence of one partner, termination of the relationship, etc.). Notice must be made within thirty-one (31) days of such change.

2. We understand that termination of this coverage (obtained as a result of completion of this Declaration) will be effective on the date the relationship ends as indicated Declaration of Termination of Domestic Partnership, providing coverage has not otherwise terminated due to standard policy provisions.

Acknowledgments

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorney's fees and costs) due to any false statements contained in this Declaration or for failure to notify Atkins of changed circumstances as required in the above section. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify Atkins of changed circumstances pursuant to the above sections, may lead to disciplinary action against me, including discharge from employment.

2. We have provided the information in this Declaration for use by Atkins for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree that Atkins is not legally required to extend any such benefits. We understand that this information provided in this Declaration will be treated as confidential by Atkins but will be subject to disclosure: a) upon the express written authorization of the undersigned employee, b) upon request of the insured or plan administrator, or c) if otherwise required by law.

3. We understand that this Declaration may have legal implications relating, for example, to our ownership or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.

4. In the event that this Declaration conflicts with state or local ordinances, such ordinances shall take precedence.

Affirmation

We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

_____	_____	_____
Employee Signature	**Date of Birth**	**Date**
_____	_____	_____
Domestic Partner Signature	**Date of Birth**	**Date**

Employee & Domestic Partner Address:

_____

_____