State of Iowa
Affidavit of Domestic Partnership

I. DECLARATION
We, (Print name of Employee) ____________________________________________________________, and
________________________________________________________ (Print name of Domestic Partner)
being duly sworn

under oath, do certify and declare that we are domestic partners in accordance with the following
criteria and are eligible for health and dental insurance under the State Employee Benefits Program:

II. DOMESTIC PARTNER CRITERIA
1. We are each other’s sole Domestic Partner and intend to remain so indefinitely and are
responsible for our common welfare.
2. We agree to financially support each other during the time of our domestic partner relationship
by being jointly responsible for each other’s necessities, including without limitation, food,
clothing, housing and medical care.
3. We are not legally married to anyone.
4. We are at least eighteen (18) years of age or older and are mentally competent to consent to
this contract.
5. We are not related by blood closer than would bar marriage in our state of residence.
6. This relationship has been in existence for a period of at least twelve (12) consecutive months,
and we have jointly shared the same residence for at least six (6) months.
7. Our relationship meets at least three of the following four conditions (please check those that
apply, A-D):
   ___ A. We have common or joint ownership of a residence (home, condominium, or mobile
        home).
   ___ B. We have at least two of the following (please check which two apply):
           ___ 1.) Joint ownership of a motor vehicle
           ___ 2.) Joint checking account
           ___ 3.) Joint credit account
           ___ 4.) Lease for a residence identifying both partners as tenants
           ___ 5.) Durable power of attorney for health care or financial management
   ___ C. The Domestic Partner has been designated as the primary beneficiary for at least one
        of the following (please check which one applies):
           ___ 1.) The Employee’s life insurance contract
           ___ 2.) The Employee’s will
           ___ 3.) The Employee’s retirement contract
   ___ D. A “relationship contract” has been executed which obligates each of the parties to
        provide support for the other party and provides, in the event of the termination of the
        relationship, for a substantially equal division of any property acquired during the
        relationship.

NOTE: Documentation may be required to prove the existence of any of the above-mentioned
items.
III. CERTIFICATION OF DOMESTIC PARTNER AS A DEPENDENT

Please check one:

☐ Yes, my domestic partner qualifies as my dependent for federal income tax purposes.
   I understand that on the basis of the above statements, the State will consider the above
   person my dependent for all federal income and employment tax purposes.
   I agree to reimburse the State for any liability including, without limitation, taxes, penalties, or
   losses (including reasonable attorneys’ fees) that the State may incur arising out of its
   reliance on this affidavit if it is untrue in any respect, or if I fail to provide notice required by
   section IV.

☐ No, my domestic partner does not qualify as my dependent for federal income tax purposes.

IV. CHANGE IN DOMESTIC PARTNERSHIP

1. I, the employee, agree to notify my personnel assistant within thirty-one (31) days if there is any
   change in our status as domestic partners as attested in the Affidavit which would make the
   domestic partner and/or any of his/her dependent children ineligible for the State Employee
   Benefits Program (for example, due to death of a partner, a change in joint residence,
   termination of the relationship, etc.).

2. Upon notification, an Affidavit of Termination of Domestic Partnership shall be provided by my
   personnel assistant, which I will complete to affirm that the partnership is terminated. Domestic
   Partner coverage under the State’s Employee Benefits Program will be terminated as of the end
   of the month in which the employee’s personnel assistant receives the termination affidavit. No
   notice of the termination will be sent to the domestic partner, or the domestic partner’s
   dependents, if any.

3. After termination of the Domestic Partnership, another Affidavit of Domestic Partnership cannot
   be filed with my personnel assistant until twelve (12) months have elapsed after which I may
   enroll my Domestic Partner in my health and dental insurance subject to the State’s eligibility
   and enrollment rules.

4. I understand that when I enroll in health insurance and/or dental insurance my benefit elections
   will remain in effect until the end of the calendar year and I will not be able to make any changes
   until the next enrollment period unless I experience a qualified life event.

V. ACKNOWLEDGEMENTS

1. We recognize that domestic partner benefits are based on bargaining status and are not
   provided to all employees. We further understand that we must meet the eligibility requirements
   of the particular benefit plan(s) we are requesting. Last, we understand that the State will not
   provide COBRA rights to a domestic partner or his/her children if the partnership is dissolved, or
   if the employee terminates employment, or if the domestic partner’s dependents have an event
   that makes them ineligible for the employee’s plan.

2. We understand that if both the “employee” and “domestic partner” are State employees eligible
   for health and dental insurance, then selection of family coverage under the domestic partner
   provision effectively waives any right of either party to single coverage benefits or contributions
   during the time the partnership is in effect.

3. We understand that any person, employer, or company who suffers any loss because of false
   statements contained in this “Affidavit of Domestic Partnership” may bring civil action against
   either or both of us to recover their losses, including reasonable attorney fees.
4. We provide the information in this affidavit to be used by my personnel assistant for the sole purpose of determining our eligibility for Domestic Partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our expressed written authorization or pursuant to a court order.

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

6. We have reviewed the information about domestic partner’s health and dental benefits at the University Benefits website (www.uiowa.edu/hr/benefits/domesticpart)

VI. DEPENDENT CHILD/CHILDREN OF A DOMESTIC PARTNER

I, the above named Domestic Partner, certify that the following are my eligible dependent children:

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<th>Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
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VII. AFFIRMATION

We affirm, under penalty of perjury, that the statements in this affidavit are true to the best of our knowledge. We understand that this form is not an application for insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under the State’s Employee Benefits Program.

(Print Name of Employee) (Print Name of Domestic Partner)

(Signature of Employee) (Signature of Domestic Partner)

(Employee’s Date of Birth) (Domestic Partner’s Date of Birth)

(Employee’s Social Security Number) (Domestic Partner’s Social Security Number)

(Date) (Date)

Indicate if the Domestic Partner is also a State employee by providing the department name below:

Subscribed to and sworn to before me this _______ day of ________________, 20_________

(Notary Public Signature)