

## Benefit Plan Affidavit of Domestic Partnership

STATE OF

)

| 22:  |  |
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| COUNTY OF )  |  |
| The undersigned, being duly sworn, depose and d  | leclare as follows:  |
| We are both eighteen years of age or older and unnevidence of the termination of the marriage.   | narried. If either or both of us have been married, we submit  |
| each other's sole domestic partner, have been so for a   | par marriage under the laws of the State of New York. We are at least one year prior to the date of this affidavit, and intend to mutual support, caring, and commitment, and have assumed |
| We have been living together on a continuous basis for of One Year Residency" form.)   | r at least one year prior to the date of this affidavit. (See "Proof   |
| One of us is enrolled in the Research Foundation Heal  | th Insurance Program.  |
| Neither of us has been registered as a member of anoth   | ner domestic partnership within the last year.   |
| I, the enrollee, affirm that I will file a "Termination of Domestic Partnership" form within 14 days of the date I or my partner no longer meets one or more of the qualifying criteria set forth above. |  |
|  | g statement made in order to receive benefits for which I do not for any benefits paid on behalf of my partner and potential   |
| Name (Enrollee)  | Name (Partner)   |
| Social Security Number   | Social Security Number/Date of Birth   |
| Address  | Address  |
| Address  | Address  |
| Signature  | Signature  |
| Sworn to before me this day of   | ate  |
| Notary Public  | _  |
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