

LAFAYETTE COLLEGE

ENROLLMENT INFORMATION FOR DOMESTIC PARTNERS OF EMPLOYEES

As a Lafayette College full-time employee, you may now receive medical coverage for a same-sex Domestic Partner under Lafayette's medical insurance program.

To enroll your Domestic Partner, you must:

1. Complete, sign and have your partner sign the attached Certification of Domestic Partnership Form.
2. Return the form to the Office of Human Resources in Markle Hall.

If you have any questions, please call the Office of Human Resources at 250-5060.

LAFAYETTE COLLEGE

CERTIFICATION OF DOMESTIC PARTNERSHIP

I. ELIGIBILITY

We, _____, (Lafayette College employee), and
_____, (domestic partner), are Domestic Partners as
defined by the following criteria:

- A. We share the same permanent residence and have done so for at least the twelve months prior to applying for Domestic Partner benefits;
- B. We have an exclusive mutual commitment;
- C. We are financially responsible for each other's welfare and debts to third parties. Evidence of this responsibility can be demonstrated by one of the following (please circle the type of documentation you are attaching to this application for Domestic Partner coverage):
 - 1. contractual commitment for each other's financial responsibilities;
 - 2. joint ownership of significant assets (such as a home or car); and/or
 - 3. joint liability for debts (such as a joint mortgage or lease).
- D. Neither of us is married to anyone else nor has another Domestic Partner;
- E. Each of us is eighteen (18) years of age or older and is competent to consent to contract including incurrence of those contractual obligations which may rise out of the domestic partnership;
- F. We are not related by blood closer than would bar marriage in the state of our residence; and
- G. We affirm, under oath, that the assertions set forth above are true to the best of our knowledge.

II. CHANGE IN DOMESTIC PARTNERSHIP

- A. We agree to notify the Lafayette College Office of Human Resources if there is any change in our status as Domestic Partners as certified in this statement which would make the Domestic Partner no longer eligible for College benefits (for example, a change in the Domestic Partner's permanent residence or if we no longer are each other's sole Domestic Partner). We will notify the College within thirty (30) days of such change by filing a Statement of Termination of Domestic Partnership ("Statement of Termination"). The Statement of Termination shall affirm that the domestic partnership status is terminated as of its date of execution and that a copy of the Statement of Termination has been mailed to the other party by the party authorizing such action.
- B. After such termination, I, _____ the undersigned Lafayette College employee, understand that a subsequent Statement of Domestic Partnership cannot be filed until twelve months after a Statement of Termination has been filed with the Office of Human Resources.

III. ACKNOWLEDGMENTS

- A. I, the undersigned Lafayette College employee, understand that under current IRS regulations unless my Domestic Partner qualifies as my legal tax dependent, the benefit paid by Lafayette College on behalf of my Domestic Partner is considered taxable income to me and will be subject to income and other applicable employment taxes. I understand that I should consult with my tax advisor regarding this issue.
- B. I, the undersigned Lafayette College employee, understand that the policy regarding documentation for domestic partners is governed by the College's policy on dependents.
- C. I, the undersigned Lafayette College employee, understand that any false or misleading statements made in order to receive benefits for which I do not qualify may subject me to disciplinary action, up to and including discharge from employment.

- D. We understand that any person, company, employer or creditor who suffers a loss because of a false statement contained in the "Certification of Domestic Partnership" may bring a civil action against us/me to recover losses they may incur.
- E. I, the undersigned Lafayette College employee, understand that commencement of coverage for Domestic Partners will be subject to the same window period (first day of next month following eligibility and application for coverage) which governs all others who are eligible for coverage.

Employee Name (Please print)

Employee Signature

Date

Domestic Partner Name (Please print)

Domestic Partner Signature

Date

Domestic Partner Social Security Number

Employee and Domestic Partner Permanent Address

LAFAYETTE COLLEGE

STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____, declare that:
Employee (print)

1. _____ and I are no longer Domestic Partners.
Name of Domestic Partner (print)
2. I make and file this Statement of Termination of Domestic Partnership in order to cancel the Statement of Domestic Partnership filed by me with Lafayette College on _____.
3. I mailed my former domestic partner a copy of this notice at this address _____ on this date: _____.
4. The termination of our domestic partnership was effective on this date: _____.

Signed: _____

Print Name: _____

Address: _____

Date: _____