



UNIVERSITY OF WYOMING

Human Resources Department – Benefits Office
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Affidavit of Domestic Partnership

Section I - Declaration

I, _____, make application for the University health insurance
(Type or print employee's name)
benefit for my domestic partner, _____.
(Type or print domestic partner's name)

The benefit will be for (check one of the boxes):

- Domestic partner only
- Domestic partner and his/her legally eligible dependents

Dependents of Domestic Partner	
Name	Date of Birth

- OR -

I, _____, am currently receiving the University health insurance
(Type or print employee's name)
benefit for my domestic partner, _____, but there has been a
(Type or print domestic partner's name)
change in the status of the domestic partnership such that it no longer meets the eligibility criteria listed below.

Section II – Eligibility Criteria

I certify that the following are true:

1. Both of us are legally competent to enter into a contract and at least 18 years of age;
2. Neither of us is in a marriage that would qualify the spouse for coverage in the State of Wyoming group health insurance plan;
3. We are not related by blood in any way that would prohibit marriage in the state in which we legally reside;
4. We are responsible for each other's common welfare and are each other's sole (same or opposite-sex) domestic partner;
5. We comply with at least one of the following conditions and related documentation can be furnished upon request:

- a. We share a common residence and understand that partners may share a common residence even if any of the following conditions apply:
 - i. Only one partner has legal ownership of the residence, if ownership is applicable, or only one partner is lessee, in the case of a lease;
 - ii. One or both partners have additional residences not shared with the other partner;
 - iii. One partner leaves the common residence with the intent to return.
 - a. We hold joint ownership of real property with rights of survivorship, or
 - b. We bear joint responsibility for a mortgage.
- 6. I participate, and will continue to participate, in the State of Wyoming health insurance plan; and
- 7. My domestic partner and legal dependents of the domestic partner will not be eligible for employer paid insurance during the period in which this benefit is received.

Section III – Change in Domestic Partnership

I agree to notify Human Resources if there is any change in our status as domestic partners as certified and acknowledged in this statement. If the partnership ends or the partner becomes eligible for coverage under an employer provided health insurance plan, coverage in benefit programs will terminate on the last day of the month in which either occurs. I will notify the University within 60 days of such change.

Section IV - Acknowledgments

- 1. I acknowledge that the University cannot guarantee that private insurance will be available as a result of this program.
- 2. I provide this information to be used by the University for the purpose of determining eligibility for benefits and for the administration of those benefits. I understand that the University will limit access to this information to the extent possible.
- 3. I affirm and declare that the information in this Affidavit is true and complete to the best of my knowledge. I understand that it is possible that this statement may create certain legal and tax obligations, rights, duties and/or liabilities, and I have been advised to seek individual legal and tax advice. I understand that the University assumes no responsibility for any resulting tax obligation.
- 4. The University reserves the right to request proof that my partnership meets the eligibility criteria, and I agree to provide supporting documents.
- 5. I understand that making any false or misleading declarations and acknowledgments in this Affidavit or failure to notify the University of any change in status as domestic partners could result in cancellation of benefit payments and possible disciplinary action.
- 6. I understand that the University reserves the right to modify its policy on domestic partner benefits at any time.
- 7. The employee receiving the domestic partner benefit must annually provide proof during an open enrollment period that follow the State Group Insurance open enrollment period, to Human Resources of the current premium being paid by the domestic partner.

Section V – Signature

Employee Signature

Date

Empl ID