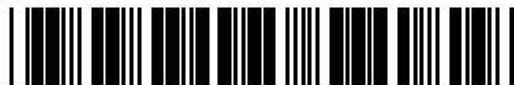


KAISER PERMANENTE®

3190

DOMESTIC PARTNER AFFIDAVIT

Instructions: 1. This form cannot be submitted online.
2. Either: a) complete online and print or b) print and complete by printing clearly using blue or black ink.
3. Items marked with an asterisk (*) are required fields.
4. When complete, fax to the number below. Be sure to retain original and the fax receipt for your records.
5. Effective date on the form is the date you and your Domestic Partner entered/registered into the Domestic Partner Relationship. Dependents will be added to medical and/or dental plans as defined by the benefit plan documents.
6. If you are just registering the domestic partner relationship then you will only need to complete pages 2 and 3.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00123456	(111)111-1111	02/14/2014
*** First Name**	**Middle Name**	*** Last Name**
John	X	Doe

NCAL: Effective date must be on or before Notary Public signing date.

non-NCAL Regions using this form: Effective date must be on or before Notary Public signing date AND within 31 days of submitting the form to Kaiser HR Service Center.

General Information:

To enroll your domestic partner [and child(ren) of your domestic par... information below, and complete the form as directed.

A. This enrollment form also applies to your domestic partner and th... Dependent Life and Accidental Death and Dismemberment Insur...

B. You need to notify your benefits representative if there is any cha... Affidavit of Domestic Partnership. To terminate your domestic pa... you need to file a Kaiser Permanente Termination of Domestic P... partnership filed with a local or state government to your benefits...

C. You cannot file another Kaiser Permanente Affidavit of Domestic Partnership until six (6) months after the date of filing a Kaiser Permanente Termination of Domestic Partnership. (No waiting period is applicable in the event of the death of your domestic partner.)

D. The Kaiser Permanente Affidavit of Domestic Partnership shall terminate upon the death of your domestic partner.

E. Willful falsification of information on the Kaiser Permanente Domestic Partner Affidavit or in the local or state government domestic partner registry will lead to termination of benefits coverage and may lead to disciplinary action, up to and including recovery of the cost of any benefits provided as well as discharge from employment.

Important information about changes to the definition of dependent: Recent laws have changed the federal tax code sections that define who qualifies as a dependent with regard to tax-free coverage for certain employee benefits, including medical and dental benefits. A child of a domestic partner cannot be claimed as a dependent of an employee if the child can be the "qualifying child" of the domestic partner or another taxpayer. In most cases, the child of a domestic partner cannot be the dependent of an employee unless that child has been adopted by the employee.

If you have previously enrolled a domestic partner's child as a dependent, that dependent may no longer qualify for tax-free medical and dental coverage. Due to the change in the law, the fair market value of this coverage may now be considered taxable income.

1. DOMESTIC PARTNER

Every page of the Affidavit must be signed and dated by Employee

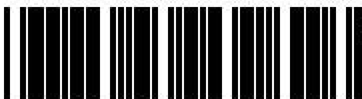
Select One:

☐ My domestic partner and I have registered our relationship with a local or state government domestic partner registry. Attached is a copy of our certified registration.

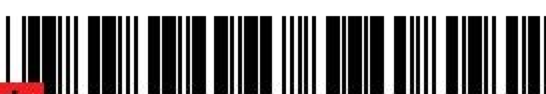
☐ My domestic partner and I have not registered our relationship with a local or state government domestic partner registry so we are registering our relationship by completing the attached Kaiser Permanente Affidavit of Domestic Partnership.

John Doe	06/01/2014
* Employee Signature	* Date (mm-dd-yyyy)

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist



KAISER PERMANENTE.



All asterisk marked fields must be completed

3190 **DOMESTIC PARTNER AFFIDAVIT**

* First Name	Middle Name	* Last Name
John	X	Doe
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00123456	(111)111-1111	02/14/2014

2. DOMESTIC PARTNER AND/OR CHILDREN OF DOMESTIC PARTNER ACKNOWLEDEMENT OF SECTION 152 - INTERNAL REVENUE CODE

If I check "Yes" next to the name of my domestic partner and/or the children of my domestic partner listed below, I certify s/he is my legal tax dependent as defined under the Internal Revenue Code section 152. This means that (1) s/he receives over half of her/his support from me, (2) his/her principal place of residence is my home, (3) s/he is a member of my household and, in the case of his/her child(ren), that, (4) my domestic partner's child is not the "qualifying child" of my domestic partner or any other taxpayer. As a result, the fair market value* of medical and dental benefits provided by Kaiser Permanente shall **not** be taxable to me. I will notify my benefits representative immediately of any change in this tax dependent status.

If I check "No" next to the name of my domestic partner and/or the children of my domestic partner listed below, I understand s/he does not constitute my legal tax dependent as defined under Internal Revenue Code section 152. As a result, the fair market value of medical and dental benefits provided by Kaiser Permanente on his/her behalf shall be taxable to me and such taxes will be withheld from my paycheck every pay period.

If your domestic partner qualifies as your legal tax dependent, but his/her child(ren) do not, check "Yes" for your domestic partner and "No" for his/her child(ren). If yo[...] e fair market value of the dependent benefi[...]

☐ I have registered my domes[...] the guidelines established by the state of [...] estic partner will be exempt from Califor[...]

This section MUST have one option selected before your Domestic Partner can be enrolled in benefits. There are tax implications for the value of the benefits they receive, please consult a tax professional as needed.

Domestic Partner

* Name (First, Middle, Last)			
Jane X Doe			
* Sex	* IRS Dependent	* Date of Birth (mm/dd/yyyy)	* Social Security Number - (SSN) (xxx-xx-xxxx)
☒ Female ☐ Male	☒ Yes ☐ No	01/01/1970	111-11-1111

Domestic Partner's Children

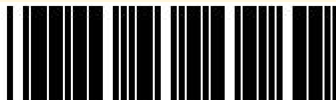
Name (First, Middle, Last)			
Sex	**IRS Dependent**	Date of Birth (mm/dd/yyyy)	Social Security Number (xxx-xx-xxxx)
☐ Female ☐ Male	☐ Yes ☐ No		
Name (First, Middle, Last)			
Sex	**IRS Dependent**	Date of Bir[...]	
☐ Female ☐ Male	☐ Yes ☐ No		

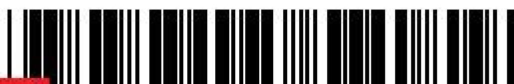
Use additional forms for more members.

Each page must be signed & dated by employee. This page must also be signed and dated by the Domestic Partner.

Employee Signature	Date (mm-dd-yyyy)	Domestic Partner Signature	Date (mm-dd-yyyy)

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist





KAISER PERMANENTE®

All asterisk marked fields must be completed

3190 **DOMESTIC PARTNER AFFIDAVIT**

* First Name	Middle Name	* Last Name
John	X	Doe
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00 123456	(111) 111-1111	02/14/2014

I, ______________________ ceritfy that ______________________
Print Name — Print Domestic Partner's Name

and I are domestic partners and that we:

1. Live together, sharing the same living quarters as our primary residence, in an intimate,committed relationship of mutual caring;
2. Have no other domestic partner at this time;
3. Are responsible for each other's basic living expenses during our domestic partnership, and agree to be financially responsible for any debt each other incurs as a result of Kaiser Permanen
4. Are not married to anyone;
5. Are each 18 years of age or older;
6. Are not related to each other as a parent, brother or sister, ... or grandchild;
7. Have not been covered by Kaiser Permanente sponsored ... t six (6) months (this last condition does not apply if your prior dom

These fields must be completed, signed, and dated by both the Employee and the Domestic Partner

Employee Signature	Date (mm-dd-yyyy)	Domestic Partner Signature	Date (mm-dd-yyyy)

Employee / Domestic Partner Information

Employee Social Security Number (SSN) (xxx-xx-xxxx)	Phone Number (###) ###-####	Domestic Partner SSN (xxx-xx-xxxx)

NOTARIZATION

State Of	County Of	Notary Public - (Print Name)

On ______________ before me, ______________________ personally appeared
(insert name and title of the officer)

______________________ ______________________
(insert name of ... (insert name of domestic partner)

who proved to me on the basis of ... ne(s) is/are subscribed to the within instrument and acknowledged to me that he/ ... d capacity(ies), and that by his/her/their signature(s) on the instrument th ... son(s) acted, executed the instrument. I certify under PENALTY OF PERJURY u ... oing paragraph is true and correct.

The date signed by the Notary must be on or later than the Effective Date at the top of the page. The form must be submitted within 31 days.

Seal

Notary Public Signature

My Commission Expires (mm/dd/yyyy)

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist