



**MEMORANDUM**

**To:** Employees of the Alhambra Unified School District Eligible for Benefits  
**From:** Patti Allara, Director of Risk Management  
**Subject:** Domestic Partner Coverage

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The domestic partner (and his/her's eligible dependent child(ren)) of an employee participating in any District Group Health Plan will be eligible for coverage when the following criteria are met. The eligible employee and domestic partner must:

- be unmarried, unrelated to each other by blood in any way, and not a member of another domestic partnership for the prior six months;
- have a common residence, sharing the common necessities of life and responsibility for each other's common welfare, including financial interdependence;
- be at least 18 year of an age.

To obtain coverage, both the employee and his/her partner will be asked to certify to these eligibility requirements. To insure confidentiality and protect your privacy, all eligibility questions, enrollment forms and documentation reviews will be personally handled by me. I recommend that you call me on my direct line, (626) 308-2700. Private voice mail is available if I'm unavailable to immediately take your call.

- Employees must enroll their domestic partner (and eligible dependent child(ren)) during their initial eligibility period, unless at that time, the domestic partner does not meet the criteria outlined above. If the above criteria are met beyond the initial eligibility period, the domestic partner (and eligible dependent child(ren)) can only be added within 30 days from the date on which all elements of the criteria are met. A domestic partner (and eligible dependent child(ren)) who are not enrolled within that 30 day period, shall be eligible for enrollment during the subsequent Open Enrollment Period, with coverage effective on November 1<sup>st</sup> of that year.

It should be noted that the IRS currently requires employers to treat the value of coverage provided to a domestic partner and their dependents as taxable income to the employee. Employees are, therefore, advised to review the consequences of electing this benefit with their own tax advisors.

Domestic partner (and eligible dependent child(ren)) coverage is available in our group Medical, Dental, Vision and Life insurance Plans. Employee contributions for dependent coverage may be required for some of these Plans.

Thanks.

PA

# ALHAMBRA UNIFIED SCHOOL DISTRICT

## AFFIDAVIT OF DOMESTIC PARTNERSHIP

I, \_\_\_\_\_, submit this Affidavit of Domestic Partnership to  
(Name of Employee)

establish \_\_\_\_\_ as my Domestic Partner (as defined below) for the  
(Name of Domestic Partner)

purpose of enrolling in the Group Health Plan(s) extended to employees of the Alhambra Unified School District.

I and \_\_\_\_\_ are a Domestic Partnership.  
(Name of Domestic Partner)

“Domestic Partner” means two adults who have chosen to share their lives in an intimate and committed relationship, reside together, and share a mutual obligation of support for the basic necessities of life.

Specifically, I declare and acknowledge that I and my Domestic Partner named above meet the following criteria:

- We are both at least 18 years of age;
- We are unmarried, unrelated by blood in any way, and are not now nor have been a member of another domestic partnership within the prior six months;
- We share a common residence together and intend to do so permanently;
- We are mutually and jointly responsible for each other’s basic living expenses.

### Plan Enrollment

In addition to this Affidavit, I must complete any and all appropriate Plan enrollment forms. I can elect to enroll my Domestic Partner and his/her’s eligible dependent child(ren). Eligible dependent child(ren) are defined by the individual group health Plans. Domestic Partner coverage is requested for the following Plans (please indicate all applicable):

- Medical
- Dental
- Vision
- Life

**Please refer to the Tax Information Exhibit for the tax consequences of this benefit. Employees are advised to review the consequences of electing this benefit with their tax advisors.**

Statement of Disenrollment - Termination of Domestic Partner or Death

I am obligated to file a Statement of Disenrollment within 30 days of the date on which the criteria of a Domestic Partner relationship, listed in the Affidavit of Domestic Partnership, are no longer met.

The Statement must also be filed within 30 days of the date of the death of my Domestic Partner.

The Statement may also be filed at any time I wish to disenroll my Domestic Partner and eligible dependent child(ren), if any, from the group Plan(s).

I cannot file another Affidavit of Domestic Partnership for a new Domestic Partner until at least six months has elapsed from the date the previous Statement of Termination of Domestic Partner was filed.

Continuation Coverage for Domestic Partners

Although a Domestic Partner (and his/her dependent child(ren)) does not have rights to COBRA coverage under existing federal law, continued coverage at the COBRA rate applicable to each Plan will be offered in accordance with the existing laws and requirements for such coverage for any dependent becoming a qualified beneficiary.

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I, \_\_\_\_\_, understand that I am responsible for reimbursement of  
(Name of Employee)

any expenses incurred as a result of any false or misleading statement contained in this Affidavit of Domestic Partnership.

I affirm, under penalty of perjury, that the statements in this Affidavit are true to the best of my knowledge.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Employee)

\_\_\_\_\_  
(Name of Domestic Partner)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Signature of Domestic Partner)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Notary Seal)

\_\_\_\_\_  
(Signature of Notary Public and Date)



**ALHAMBRA UNIFIED SCHOOL DISTRICT**

**STATEMENT OF DISENROLLMENT, TERMINATION OR DEATH  
OF DOMESTIC PARTNER, OR CANCELLATION  
OF COVERAGE OF DEPENDENT CHILD(REN)**

I, \_\_\_\_\_, make and file this Statement of Disenrollment,  
(Name of Employee)

Termination or Death of Domestic Partner in order to cancel the Affidavit of Domestic Partnership previously filed. The Statement should also be completed to cancel the coverage of dependent child(ren).

I wish to cancel, effective immediately, the Affidavit of Domestic Partnership previously filed with respect to \_\_\_\_\_  
(Name of Domestic Partner)

**BECAUSE**

The Domestic Partner relationship between me and \_\_\_\_\_  
(Name of Domestic Partner)  
ended on \_\_\_\_\_.  
(Date)

**OR**

My Domestic Partner, \_\_\_\_\_, died on \_\_\_\_\_.  
(Name of Domestic Partner) (Date of Death)

- For Cancellation of Coverage of Dependent Child(ren)

I wish to cancel, effective immediately, the coverage previously filed with respect to:

_____	_____
(Name of Dependent Child)	(Reason - other coverage, overage dependent, etc.)
_____	_____
(Name of Dependent Child)	(Reason)
_____	_____
(Name of Dependent Child)	(Reason)
_____	_____
(Name of Dependent Child)	(Reason)
_____	_____
(Name of Dependent Child)	(Reason)

For Termination of Plan Coverage of Domestic Partner and/or Dependent Child(ren)

I understand that if my Domestic Partner was previously covered by any of my employer's Group Health Plan(s), the effect of filing this Statement of Disenrollment, Termination or Death of Domestic Partner or Cancellation of Plan Coverage of Dependent Child(ren) is that my Domestic Partner, and his/her eligible dependents, if any, will no longer be covered by my employer's Plan(s).

I further acknowledge that it is my responsibility to mail a copy of this signed statement to my former Domestic Partner, or surviving Domestic Partner, named above.

**Specific Plan Change Notice(s) may need to be completed in addition to this document.**

I affirm that the information in this Statement is true to the best of my knowledge.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Name of Employee)

\_\_\_\_\_  
(Signature of Employee)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip Code)

(Notary Seal)

\_\_\_\_\_  
(Signature of Notary Public and Date)