| | City of Durham, NC<br><br>Policy Memorandum | Effective Date | Number |
|---|---|---|---|
| To: | Assistant City Managers and<br>All Department Heads | Manual<br>Human Resources | Revision |
| Signature: | | Subject: Domestic Partner Coverage | |
| Comments: **PLEASE POST** | | | |

**PURPOSE:**
To establish a policy allowing eligible employees to enroll as dependents certified domestic partners and the dependents of certified domestic partners in the City health and dental plans.

**POLICY:**
The City will allow eligible Regular Full-time, Temporary with Benefits and designated Regular Part-time employees to enroll as dependents those who have been determined by this policy to be domestic partners or the legal dependents of that domestic partner.

To the extent allowed under the contract with our insurance carriers, the City will provide medical and/or dental benefits to same sex or opposite sex domestic partners of City of Durham employees on the same basis as they are make available to the spouses and the children of spouses of married employees.

**Definition of Terms used in this Policy**
**Domestic Partner**
Two individuals who have reached the age of majority and live together in a long-term relationship of indefinite duration, with an exclusive mutual commitment in which the partners share the necessities of life and are financially interdependent. Also, domestic partners are not married to anyone else, do not have another domestic partner and are not related by blood more closely than would bar their marriage in this State.

**Dependent of Domestic Partner**
The legal dependents of the City of Durham employee's domestic partner. The dependant of the domestic partner being covered must meet all of the eligibility requirements that are required of other covered dependents of an employee or the dependents of the spouse of an employee.

**PROCEDURE:**
The City will allow employees to enroll domestic partners and the dependents of domestic partners in the health and or dental health care plans who satisfy the policy and have completed the following requirements.

A. Employees interested in applying for the domestic partner coverage must contact the Benefits Representatives in Human Resources during the initial enrollment period for their employment or when the requirements for domestic coverage are met.

B. The employee must complete and have notarized, the required Affidavit of Domestic Partnership and the enrollment application form for the health and dental plans and provide documentation that the domestic

partner relationship has existed for at least six months. The Human Resources Department will determine if the information provided satisfies the requirements to determine eligibility of domestic partner coverage. This includes:

1) Acknowledgment of responsibility for one another's financial welfare. Example:
    a. Affidavit accepting liability for each other's living expenses and debts to third parties
    b. Document indicating the shared responsibility for home mortgage or rental lease.
    c. Document indicating the shared responsibility for property owned or being purchased such as land, car, furniture or personal loan.
    d. Document of a will, insurance agreement, or pension fund naming the partner a primary beneficiary

2) Agreement to make decisions pertaining to each other's care in time of medical emergency or after death. Example:
    a. Document indicating a executed health care agreement,
    b. Document indicating the appointment of the partner as employee's estate executor

C. The Human Resources Department will enroll the employee's domestic partner and if applicable, the dependent/s of the domestic partner in the desired health and/or dental coverage effective on the first day of the month following the date of the completion of the enrollment process.

D. The change in the coverage level will be made to the City benefits and payroll systems and any premium increases will be payroll deducted from the employees next bi-weekly payroll check. Because the City pays for coverage one month in advance there may include additional premiums that are due for the coverage being provided.

E. The coverage provided for the domestic partner and the dependents of domestic partners is the same coverage that is provided to regular employee and the same guidelines and rules must be followed to insure appropriate benefits and service.

F. It is the responsibility of the employees to contact the Human Resources Department and inform the Benefits Representative within 31 days of the ending of the relationship under which the domestic partner coverage has been extended. Employees wishing to discontinue the domestic partner coverage must complete the Termination of Domestic Partner Coverage Form. It is the responsibility of the employee to inform the domestic partner and the dependents of the domestic partner of the termination of the domestic partner coverage. Following the termination of coverage the City does not make available COBRA continuation of health and/or dental coverage for the former domestic partner and if applicable the dependent/s of the domestic partner.

G. The employee has the responsibility to provide accurate and current information when enrolling a domestic partner or the dependent/s of a domestic partner. The City may take civil action against any employee for any losses, including medical cost, reasonable attorney fees and court cost, because of any willful falsification of the information contained in the Affidavit of Domestic Partnership. This includes expenses related to premiums paid by the City for the coverage of the domestic partner or the dependent/s of the domestic partner that no longer meet the eligible guidelines of this agreement.

**Eligibility Criteria**

The City of Durham employee can cover a domestic partner when they meet the following criteria.

A. The employee and domestic partner are engaged in a committed relationship for mutual support and benefit, and have been in such a relationship for a period of at least six months.

B. Both are jointly responsible for each other's material support as evidenced by joint living arrangements, joint financial arrangements, joint ownership of real or personal property, or similar arrangements.

C. Both are of the age of consent in the jurisdiction in which they reside.

D. Both the employee and the domestic partner are not married to another person.

E. Both are not related by blood closer than permitted under the marriage laws of the jurisdiction in which they reside, and

F. Both are not engaged in any other committed relationship (i.e., neither partner has another domestic partner).

# City of Durham
## Affidavit of Domestic Partnership

### Declarations and Documentation

I, _____ and I, _____

Name of Employee (Please Print) Name of Domestic Partner (Please Print)

currently residing at _____ _____ _____ _____

Street Address City State ZIP Code

declare that we are domestic partners as defined in the Domestic Partner Policy as stated in this Affidavit.

**Definition of Domestic Partners**: The City of Durham employee and another person who have reached the age of 18 majority and live in a long term relationship of indefinite duration, with the exclusive mutual commitment in which they share the necessities of life and are financially interdependent. They are not married, nor have another domestic partner, and are not related by blood more closely than would bar their marriage in this State.

**Declaration of the Partners:** We declare that we currently share, and have shared for at least 6 months, a common residence and are no less than 18 years of age.

We further declare that we share the following rights and responsibility of a domestic partner relationship, and we demonstrate this relationship by producing documentation from both categories specified below, to confirm that we share these rights and responsibilities and that these relationships have been in place for at least 6 months:

1) Acknowledgment of our financial interdependence, and responsibility for one another's financial necessities and well-being. Examples:
    a. Affidavit accepting liability for each other's living expenses and debts to third parties
    b. Document indicating the shared responsibility for home mortgage or rental lease.
    c. Document indicating the shared responsibility for property owned or being purchased such as land, car, furniture or personal loan.
    d. Will, insurance agreement, or pension fund certificate naming the partner a primary beneficiary.

2) Agreement to make decisions pertaining to each other's care in time of medical emergency or after death. Examples:
    a. Documentation of an executed health care agreement, such as a health care power of attorney.

b. A will appointing the partner as the executor as estate executor, in case of death.

## Understanding of the City of Durham employee

I, the undersigned employee, understand that subject to the general provisions described below and to eligibility provisions of the specific plans, I have the opportunity to cover my domestic partner (and his/her dependent children) under my health care and dental care plans within the same terms and with the same privileges and restrictions that apply to other dependents eligible for these plans, to the extent that such eligibility is legal and practicable.

I understand that to be eligible for these benefits, my partner and I must sign this affidavit and present the necessary documentation for inspection by the staff of the Human Resources Department. I understand that my partner must be enrolled in the health and/or dental plans in order to enroll his/her dependent/s children in the same plan.

I understand that I am legally responsible for any expenses related to health or dental benefits I elect for my domestic partner or for the dependent/s of my domestic partner.

I understand that the benefits I elect for my partner using this Affidavit will remain in effect until changes are made through the following events:

1. The termination from the City of Durham benefits due to my ineligibility for such benefits
2. My partner enrolls in another medical plan
3. The death of my partner
4. A change in the eligibility criteria attested to in this affidavit
5. The benefit plan changes for the next year and I elect to make changes.

I agree to provide written notice to the Human Resources Department's benefits representative if there is any change of circumstances attested to in this affidavit within 31 days of the change, by filing a Statement of Termination of Domestic Partnership. I understand that after the termination, another Affidavit of Domestic Partnership cannot be filed until at least six months after the termination of the previous partnership and the filing of a Statement of Termination of Domestic Partnership, whichever date is later. I also understand that I must meet the criteria for enrolling a domestic partner.

I understand that under current tax regulations, the City of Durham is required by the IRS to report the cost related to covering my domestic partner, and any dependents of my partner covered under the benefits plans, as taxable income.

I understand that my domestic partner and the dependents of my domestic partner are eligible for continuation of coverage under COBRA regulations.

## Understanding of the Couple:

We understand that the information contained in the Affidavit will be held confidential and will be disclosureed by the City only upon receipt by the City of written authorization signed by the employee, or as required by law.

We understand that a civil action may be brought against either of us for any losses, including medical costs, reasonable attorney fees and court costs, because of willful falsification of the information contained in the Affidavit of Domestic Partnership. This includes expenses related to premiums paid by the City for the coverage of the domestic partner or the dependents of the domestic partner once they no longer meet the domestic partner eligibility guidelines, as provided in this Affidavit.

We understand that, in addition to the eligibility requirements of the City of Durham for domestic partnership coverage, there may be terms and conditions set forth in the contracts or service agreements with the health and dental insurance providers to which we agree to be bound.

We understand the willful falsification of information contained in this affidavit may result in termination of our health or dental enrollment selected for coverage.

We further understand that the rights and declarations set forth in this document may have consequences beyond those contemplated herein.

## Dependent/s of Domestic Partner – Certification

**Domestic Partner Dependent/s**

_____ ____/____/____
Last Name _____/_____/_____ First Name MI Date of Birth Social Security #

_____ ____/____/____
Last Name _____/_____/_____ First Name MI Date of Birth Social Security #

_____ ____/____/____
Last Name _____/_____/_____ First Name MI Date of Birth Social Security #

_____ ____/____/____
Last Name _____/_____/_____ First Name MI Date of Birth Social Security #

We hereby certify that the above named dependents of the domestic partner meet all of the eligibility requirements listed below for coverage under the group health plan.

The above listed dependents reside with us, and the domestic partner is responsible for the dependents well being; or the domestic partner is required to provide coverage for the dependents by court order: or
The dependents qualify as the domestic partner's dependents for tax purposes under the federal guidelines. (Attach a copy of the federal income tax return); and

The dependents meet and will continue to meet the eligibility requirements of the Domestic Partner policy as stated in this Affidavit.

**We further acknowledge and understand:**

We have an obligation to submit to the Human Resources Benefits Manager an Affidavit of Termination of Domestic Partnership within 31 days of when domestic partner eligibility requirements are no longer met, or with 31 days of the death of my domestic partner or on the last day of the first month that the domestic partner and/or domestic partner's eligible dependents fail to continue to meet all the applicable domestic partner eligibility requirements.

The City has informed us that following the termination of employment, health care and dental care continuation will be made available through COBRA coverage. If interested in this coverage, for ourselves or for our dependents covered by this plan, it is our responsibility to enroll within 30 days through the City of Durham Human Resources Department. All of the COBRA benefits, restrictions and responsibilities will apply to this coverage.

We cannot file another Affidavit of Domestic Partnership for a new domestic partner until at least 6 calendar months after a Termination of Domestic Partnership has been filed with the City, and until the criteria has been provided documenting eligibility to enroll a domestic partner.

_____ _____ ___/___/___

**Employee Signature** **Date**

_____ ___/___/___

**Partner Signature** **Date**

**Notary Public Certification:** State of _____ County of _____

I, as a Notary Public of said State and County, do hereby certify that _____ _____ personally appeared before me and executed the foregoing instrument.

Witness my hand and seal this _____day of _____, 200__

Signature of Notary _____ My commission expires ____/_____/_____

_____ _____ ___/___/___

Human Resources Department Rep Signature Date

# Affidavit of Termination of Domestic Partnership

I, _____, make and submit to the City of Durham Human
(City of Durham Employee) Please Print

Resources Department this Affidavit of Termination of Domestic Partnership in order to cancel the Affidavit of Domestic Partnership previously filed.

The domestic partnership between me and _____, ended on
(Name of Domestic Partner) Please Print

_____/_____/_____
(Date of Termination) OR My Domestic Partner died on _____/_____/_____
(Date of Death)

If applicable, the covered dependent/s of the Domestic Partner are:

_____
Last Name First Name MI

_____
Last Name First Name MI

_____
Last Name First Name MI

_____
Last Name First Name MI

**I understand that the effect of filing this Affidavit of Termination of Domestic Partnership will be that my domestic partner and if applicable, the dependent/s of my domestic partner will no longer be covered by the City of Durham's group health and/or dental care plan.**

**I further acknowledge that it is my responsibility to mail a copy of this signed Affidavit of Termination of Domestic Partnership to my former domestic partner, named above.**

_____ _____/_____/_____
Signature of City of Durham Employee Date

_____ _____ _____
Street Address City State
Zip

**Notary Public Certification:** State of _____ County of _____
_____

I, as a Notary Public of said State and County, do hereby certify that _____ _____

personally appeared before me and executed the foregoing instrument.

Witness my hand and seal this _____day of _____, 200__

Signature
of Notary _____ My commission expires ____/_____/ _____