

S C A N T R O N[®]
Affidavit of Domestic Partnership

Employee / Domestic Partner Information

Employee Information:

Name

Employer

Health Plan Participant No.

Address

Domestic Partner Information:

Name

Employer

Address

Declaration

We certify that we are domestic partners for purposes of coverage under the **Scantron Health and Welfare Benefits Plan** (the "Plan") and meet the criteria set forth below. **We understand that any misrepresentation with respect to whether we meet the plan's terms of eligibility constitutes insurance fraud and the plan will seek to recover any benefits paid on behalf of an ineligible individual and enforce disciplinary action up to and including termination.**

By selecting this box we certify the following is true:

We are currently registered as domestic partners and confirm that neither have been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or

1. As of the date of this affidavit, we are both at least eighteen years of age and are competent to enter into a contract.
2. We are not currently married to, or in a domestic partnership with, another individual in any jurisdiction, and have not been in a marriage or domestic partnership with another individual for the last **6 months**
3. We are not related by blood to a degree of closeness that would prevent legal marriage in _____.
4. We share a common residence and have for the six (6) months prior to the date of this application. In support of this statement, we have attached _____ to this Affidavit. *[Evidence may include driver's license, tax return, applicable utility statements, title to property, leases, etc.]*

Required Documentation Provided

As partners, we are financially independent. In support of this statement, we have attached _____ to this Affidavit. *[Please provide at least two documents showing proof of the following: joint bank account(s), joint credit card(s), joint obligation on a loan, status as an authorized signatory on the partner's bank account, credit card or charge card, joint ownership of holdings or investments, joint ownership of residence, joint ownership of real estate other than residence, listing both partners as tenants on the lease of a shared residence, shared rental payments (need not to be shared 50/50), a common household and shared household expenses (i.e. utilities, telephone bill, etc.)*

Taxability of Premiums and Imputed Income

Please consult a tax advisor before you complete this section, which asks for certification whether your domestic partner is a dependent as defined by the Internal Revenue Code.

Please check one:

- No, my domestic partner (and his/her children) does not qualify as my dependent for Federal income tax purposes. I understand that I will be taxed on imputed income for the portion of premiums paid by the company for my domestic partner (and his/her children), and my domestic partner (and his/her children) cannot participate in the company's Flexible Benefits Plan.
- Yes, my domestic partner (including his/her children) qualifies as my dependent for Federal income tax purposes. I understand that on the basis of the above statements, the company will consider the above person (and his/her children) my dependent for all federal income and employment tax purposes, and as a result any premiums paid by the company for my domestic partner (and his/her children) will not be treated as taxable income to me.

Declaration

We have provided the information in this Affidavit for use by _____ for the sole purpose of determining eligibility for domestic partner benefits under the Plan. We are aware that a change in domestic partnership is relevant to the Plan's provision of benefits and must be reported immediately. We agree to notify _____ in writing **within 30 days** if there is any change in our status as domestic partners, including any of the information attested to in this Affidavit, which would make us no longer eligible for employee or domestic partner coverage.

Once we provide notice of a change in domestic partner status, we understand that another Affidavit of Domestic Partnership cannot be filed until **6 months** after the date of the filing of a written statement of the termination of a prior domestic partnership.

We attest that the above information is true and accurate. We acknowledge and understand that any misrepresentation as to eligibility constitutes insurance fraud and will result in employment discipline, up to and including discharge. Further, we understand and agree that the Plan or insurer **can recover any amounts paid on behalf of ineligible individuals**. We understand and agree that _____, the Plan or an insurer may rescind our health care coverage back to the effective date of our coverage if _____, the Plan or an insurer concludes that any misrepresentations in this Affidavit constituted fraud or were an intentional misrepresentation of material fact.

Employee

Domestic Partner

Signature

Signature

Printed Name: _____

Printed Name: _____

Date: _____

Date: _____

State of _____

On this ____ day of _____, 20____, personally appeared the above named
_____ and _____, and swore to the truth of the
foregoing.

Before me,

[Seal]

Notary Public/Attorney at Law

My Commission Expires: _____