

AFFIDAVIT OF SAME-SEX DOMESTIC PARTNERSHIP OR ADULT DEPENDENT RELATIVE RELATIONSHIP

UBEN 155A (10/00) University of California Human Resources and Benefits

Send completed form to:
Health & Welfare &
Work/Life Programs
P.O. Box 24570
Oakland, CA 94623-1570

This affidavit is required when enrolling a same-sex domestic partner and/or a same-sex domestic partner's child(ren) or grandchild(ren), or an adult dependent relative. This affidavit is intended solely to inform the University of California of eligibility for benefits according to plan provisions. It is not intended to establish any contractual rights or obligations between the employee/annuitant and his/her same-sex domestic partner or adult dependent relative.

DECLARATION

We, _____ and _____, certify that
(employee/annuitant: print name) (same-sex domestic partner/adult dependent relative: print name)

we are same-sex domestic partners or have an adult dependent relative relationship in accordance with the criteria on the back of this form and are eligible for insurance coverage through the University of California.

ACKNOWLEDGMENTS

By signing this affidavit, we (the employee/annuitant and same-sex domestic partner or adult dependent relative) acknowledge that:

1. Same-sex domestic partners and adult dependent relatives are subject to the same guidelines that govern all other participants in the benefit plans. The Group Insurance Regulations and the insurance contracts govern all questions of coverage.
2. The University of California requires proof that a same-sex domestic partnership meets joint residency and financial interdependence criteria or requires verification of relationship to an adult dependent relative and proof of tax dependency. As the employee/annuitant, I agree to these provisions, and I will submit copies of supporting documentation for my same-sex domestic partnership or adult dependent relative relationship upon request. (See reverse for documentation requirements.)
3. The University will assume that my same-sex domestic partner and my partner's child(ren) and/or grandchild(ren), if any, are not my tax dependents. Under this assumption, the value of University-paid health coverage at group insurance rates for these family members will be reported as my wages for income tax and FICA withholding purposes, in accordance with the Internal Revenue Code.
4. If my same-sex domestic partnership terminates or my adult dependent relative becomes ineligible for coverage, I, as the employee/annuitant, must provide documentation of the termination or loss of eligibility within 31 days of the event. Coverage will terminate as of the end of the month my same-sex domestic partner or adult dependent relative is no longer eligible. I understand that it is my responsibility to provide my same-sex domestic partner or adult dependent relative with a copy of the termination form and the date coverage under the University plans ends. (See "Termination of Same-Sex Domestic Partnership or Adult Dependent Relative Relationship" on reverse.)
5. As the employee/annuitant, I understand that at least six months must elapse from the date my same-sex domestic partnership ends or my adult dependent relative becomes ineligible for coverage before I can enroll another same-sex domestic partner or adult dependent relative.
6. As the employee/annuitant, I am submitting this affidavit with the understanding that it will be used by the University for the sole purpose of determining benefits eligibility for my same-sex domestic partner or adult dependent relative.
7. Making false statements about satisfying the eligibility criteria or failing to notify the University of a change in status within 31 days may lead to legal action. In addition, employees will be subject to disciplinary action and will be responsible for any employer contribution and benefits paid by the plan.
8. As the employee/annuitant, I understand that the benefits of all employees and annuitants are subject to change or termination at the time of contract renewal or any other time by the University or other governing authorities. The University also reserves the right to determine new premiums and employer contributions at any time. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.
9. As the employee/annuitant, I have read and agree to the Same-sex Domestic Partner Criteria or the Adult Dependent Relative Criteria on the back of this form.

EMPLOYEE/ANNUITANT—Complete this section as applicable

What is your adult dependent relative's family relationship to you (e.g., mother)? _____

Is your adult dependent relative a full-time or part-time student? YES / NO

Is your legal spouse or same-sex-domestic partner a University employee or annuitant? YES / NO

REQUIRED SIGNATURES

As the employee/annuitant, I declare under penalty of perjury that the statements above are true and complete to the best of my knowledge. I understand that it is possible that this affidavit could have the effect of imposing on me legal or other obligations to my same-sex domestic partner or adult dependent relative or to the creditors of my same-sex domestic partner or adult dependent relative.

CHECK ONE: Same-sex Domestic Partner Adult Dependent Relative

| | | | |
|------------------------------|---------------------|---|---------------------|
| EMPLOYEE/ANNUITANT SIGNATURE | DATE | DOMESTIC PARTNER/ADULT DEPENDENT RELATIVE SIGNATURE | DATE |
| PRINT NAME | SOCIAL SECURITY NO. | PRINT NAME | SOCIAL SECURITY NO. |

RETN: Pending

SEE REVERSE FOR PRIVACY NOTIFICATIONS

Please photocopy this form for your records.

SAME-SEX DOMESTIC PARTNER**ADULT DEPENDENT RELATIVE****Criteria**

1. We are each other's sole domestic partner and intend to remain so indefinitely. We are in a relationship of mutual support, caring, and commitment. We are financially interdependent.
2. We are of the same sex, neither one of us is legally married, and we are not related by blood to a degree of closeness which would prohibit legal marriage in the State of California.
3. We are at least 18 years of age and have the capacity to enter into a contract.
4. We have resided together for at least six months and intend to reside together indefinitely.
5. It has been at least six months since the termination of a previous same-sex domestic partnership.

Required Documentation

Employee/annuitant must submit upon request at least three of the following items:

- joint mortgage or joint tenancy on a residential lease
- joint bank account
- joint liabilities (e.g., credit cards or car loans)
- joint ownership of significant property (e.g., cars)
- durable property or health care powers of attorney
- wills, life insurance policies or retirement annuities naming each other as primary beneficiary
- written agreements or contracts showing mutual support obligations or joint ownership of assets acquired during the relationship

Criteria

1. My adult dependent relative is incapable under California law of a valid marriage to me because of a family relationship. Eligible adult dependent relatives include parents, children, ancestors and descendants of every degree—grandparents, grandchildren, great-grandparents, great-grandchildren—brothers, sisters, half-brothers, half-sisters, uncles, aunts, nieces, and nephews.
2. My adult dependent relative is 18 years of age or older and not entitled to Medicare Part A.
3. My adult dependent relative resides with me and is claimed as my income tax dependent.
4. It has been at least six months since the termination of a previous adult dependent relative relationship.

Required Documentation

Employee-annuitant must submit upon request the following items:

- employee/annuitant birth certificate
- adult dependent relative birth certificate
- other birth certificate(s) and/or documentation required to show family relationship

TERMINATION OF SAME-SEX DOMESTIC PARTNERSHIP OR ADULT DEPENDENT RELATIVE RELATIONSHIP

EMPLOYEES: Complete and submit form UPAY 850 (*Enrollment, Change, Cancellation, or Opt Out*) within 31 days of the termination date.

ANNUITANTS: Complete and submit form UBEN 100 (*Continuation, Enrollment, Change, or Cancellation—Annuitant Medical, Dental and/or Legal Plan*) within 31 days of the termination date.

As the employee/annuitant, I understand that, by submitting a cancellation form, the *Affidavit of Same-sex Domestic Partnership or Adult Dependent Relative Relationship* (UBEN 155A) attested to and filed by me with the University shall be and is terminated.

PRIVACY NOTIFICATIONS**STATE**

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting the information on this form is for payment of earnings and for miscellaneous payroll and personnel matters such as, but not limited to, withholding taxes, benefits administration, and changes in title and pay status. University policy and state and federal statutes authorize the maintenance of this information. (B)

Furnishing all information requested on this form is mandatory—failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be used by various University departments for payroll and personnel administration, and will be transmitted to the federal and state governments as required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is the Associate Vice President—University of California Human Resources and Benefits, 1111 Franklin Street, Oakland, CA 94607-5200.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. Disclosure of the Social Security number is required pursuant to sections 6011 and 6051 of Subtitle F of the Internal Revenue Code and with Regulation 4, Section 404.1256, Code of Federal Regulations under Section 218, Title II of the Social Security Act, as amended. The Social Security number is used to verify your identity. The principal uses of the number shall be to report (1) state and federal income taxes withheld, (2) Social Security contributions, (3) state unemployment and Workers' Compensation earnings, (4) earnings and contributions to participating retirement systems, and (5) as an identifier for your insurance carrier to verify your eligibility and to maintain claim records for you and your eligible dependents. (AA)