

We understand that domestic partners are subject to the other eligibility provisions of the Health Trust benefit plans.

We agree to notify the Maine Municipal Employees Health Trust and the employee's employer within thirty (30) days of the termination of our domestic partnership. A written termination statement shall be provided and shall affirm that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner.

We certify, under penalty of perjury, that the foregoing is true and correct. We, the undersigned employee and the Domestic Partner, understand that falsification of information contained in this Affidavit may cause immediate termination of Health Trust health and/or dental plan coverage, and may subject us to civil action to recover any losses, including reasonable attorney's fees incurred by the Maine Municipal Employees Health Trust for benefits provided under its health and/or dental plans. We also understand that falsification of information contained in this Affidavit may lead to disciplinary action, up to and including immediate termination of the employee's employment.

Signature of Employee

Date

Signature of Domestic Partner

Date

A. Dependent Child Certification

I, _____ certify that my Partner's child(ren) named below meet the following requirement:
Subscriber Name

1. I, the subscriber, have a court-appointed legal relationship with the child(ren) (i.e., adoption, guardianship), and my Partner is the biological parent, or legal guardian of the child(ren).

Partner's Dependent Child(ren)

Last Name

First Name

M.I.

Last Name

First Name

M.I.

Last Name

First Name

M.I.

Last Name

First Name

M.I.

I understand that falsely certifying as to dependent's eligibility or failure to inform the Health Trust when a dependent no longer meets applicable eligibility requirements may cause immediate termination of Health Trust health and/or dental plan coverage, and may subject me to civil action to recover any losses, including reasonable attorney's fees incurred by the Maine Municipal Employees Health Trust for benefits paid on behalf of the dependent child(ren) named above under its health and/or dental plans. I also understand that falsely certifying as to a dependent's eligibility or failure to inform my employer when a dependent no longer meets applicable eligibility requirements may result in disciplinary action, up to and including immediate termination of employment.

Signature of Employee

Date

Approved by the Maine Municipal Employees Health Trust

By: _____

Signature

Date

Title

The following section is for certification to an employer of the legal tax dependent status of a domestic partner.

B. Partner Certification as a Tax-Qualified Dependent

Based on consultation with a tax advisor, I certify that the previously named person whom I am enrolling for coverage is my legal tax dependent as defined in the IRS Code Section 152. I understand that falsification of this certification of dependency status may result in disciplinary action, up to and including immediate termination of employment, as well as potential charges of tax fraud. I agree to notify my employer immediately of any change in this tax status.

By: _____
Signature of Employee

Date