

**Affidavit of Domestic Partnership  
For STA Vision Benefit**

We \_\_\_\_\_ (“Member”) and  
(Member – print name)

\_\_\_\_\_ (“Domestic Partner”)  
(Domestic Partner – print name)

each certify and declare that we are domestic partners in accordance with the following criteria:

**STATUS:**

1. We are each other’s sole domestic partner, we have shared the same regular and permanent residence in a committed relationship for at least 12 months and we intend to do so permanently.
2. Neither of us is married to or legally separated from anyone else nor have had another domestic partner within the past 12 months.
3. We are both at least eighteen (18) years of age and mentally competent to consent to a contract.
4. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.
5. We are engaged in a committed relationship of mutual caring and support and are jointly responsible for our common welfare and living expenses. Our interdependence is demonstrated by at least three of the following (please check appropriate items **and enclose copies of each item with this form**):

\_\_\_\_\_ Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property

\_\_\_\_\_ Common ownership of a motor vehicle

\_\_\_\_\_ Driver’s license listing a common address

\_\_\_\_\_ Proof of joint bank accounts or credit accounts

\_\_\_\_\_ Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner’s will

\_\_\_\_\_ Assignment of a durable property power of attorney or health care power of attorney

\_\_\_\_\_ Proof of registration of domestic partnership (if registration is an option in the city or county where Member and Domestic Partner reside)

6. We are not in this relationship solely for the purpose of obtaining medical and/or dental benefits coverage.
7. We understand that upon request we will provide the required documentation of our interdependence.

### **Dependent Children of Domestic Partner**

We understand that dependent children of the Domestic Partner are eligible for coverage when they are:

- unmarried;
- the Member is the court-appointed guardian of the children and the children are dependent on the Member for support;
- are under the age of 19 or age 25 if they are full time students at an accredited school;
- claimed as a dependent by the Member on his/her federal income tax return.

We understand that the provision of health care coverage to the Domestic Partner may be a taxable benefit to the Member.

### **Change in Domestic Partnership**

1. We have an obligation to notify STA Benefit Trust if there is any change in our domestic partner status as attested to in this Affidavit that would terminate this Affidavit (e.g. due to death of a partner, a change in residence of one partner, termination of the relationship, etc.) We will notify STA Benefit Trust within thirty (30) days of such change.
2. This change will be effective on the date the relationship ends of Domestic Partnership, providing coverage has not otherwise terminated due to standard policy provisions.

### **Acknowledgments**

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorney's fees and costs) due to any false statement contained in this Affidavit or for failure to notify STA Benefit Trust of changed circumstances as required above. I, the undersigned Member further understand that falsification of information in this Affidavit, or failure to notify STA Benefit Trust of changed circumstances may lead to disciplinary action against me, including discharge from employment.
2. We have provided the information in the Affidavit for use by STA Benefit Trust for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree the STA Benefit Trust is not legally required to extend any such benefits. We understand that the information provided in the Affidavit will be treated as confidential by STA Benefit Trust but will be subject to disclosure: a) upon the express written authorization of the undersigned Member, b) upon request of the insurer or plan administrator, or c) if otherwise required by law.

3. We understand that this Affidavit may have legal implications relating to, for example our marital status under applicable state “common law” marriage laws, ownership of property, or taxability of benefits provided, and that before signing this Affidavit we should seek competent legal advice concerning such matters.

We affirm, under penalty of perjury, that the statements in this Affidavit are true and correct.

Member Signature; \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date: \_\_\_\_\_

Domestic Partner Signature \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date: \_\_\_\_\_

Member and Domestic Partner Address

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Name of Dependent: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date: \_\_\_\_\_

Name of Dependent: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date: \_\_\_\_\_