Culinary Health Fund

AFFIDAVIT FOR DOMESTIC PARTNERS COVERAGE
UNITE HERE HEALTH Plan 150
Please be advised that the possession of this affidavit is not evidence of eligibility

I _____ and _____ declare ourselves to be Domestic Partners;

- We are both eighteen (18) years of age or older; and
- Neither of us is legally married; and
- We are of the same sex; and
- We are not related by blood in a manner that would bar marriage under the law; and
- We have a close and committed personal relationship; and
- We are currently living together and have been doing so on a continuous basis, prior to the date of this certificate; and
- Neither one of us has been registered as a member of a domestic partnership within the last six months; and
- We are financially interdependent, and submit proof evidencing our financial interdependence with at least two (2) of the following:

☐ A joint bank account.

☐ A joint credit card.

☐ Joint obligors on a loan.

☐ A jointly owned residence.

☐ A jointly owned motor vehicle.

☐ Wills naming each other as executor and/or beneficiary.

☐ Having conferred upon each other authority to make healthcare decisions (e.g., healthcare power of attorney)

☐ At least one of us having designated the other as beneficiary under a life insurance policy.

☐ At least one of us having designated the other as beneficiary under a retirement benefits account.

☐ Having granted each other durable powers of attorney.

☐ We are Registered NV Domestic Patners.

We understand that any falsification of registration requirements may result in termination of Culinary Health Fund benefits for both parties; and We agree to notify the Culinary Health Fund upon the ending of the Domestic Partner status. In addition, we received the tax bulletin explaining the value of this benefit, and that it is taxable. To terminate this domestic partner dependent status, both partners must complete a termination request.

Signed this _____ day of _____, 20 _____ under the penalties of perjury.

_____	_____
Fund Participant (Print Name)	Fund Participant (Print Name)
_____	_____
Social Security #	Social Security #
_____	_____
Domestic Partner (Print Name)	Domestic Partner (Signature)

I have reviewed the items of proof as specified above and have made copies of the same.

_____	_____
Fund Representative	Date

Sworn to before me this _____ day of _____, 20 _____.

(Seal)

_____
Notary Public

My Commission Expires: _____

Culinary Health Fund

AFFIDAVIT FOR DOMESTIC PARTNERS COVERAGE
UNITE HERE HEALTH Plan 150
Please be advised that the possession of this affidavit is not evidence of eligibility

I _____ and _____ declare ourselves to be Domestic Partners;

- We are both eighteen (18) years of age or older; and
- Neither of us is legally married; and
- We are of the same sex; and
- We are not related by blood in a manner that would bar marriage under the law; and
- We have a close and committed personal relationship; and
- We are currently living together and have been doing so on a continuous basis, prior to the date of this certificate; and
- Neither one of us has been registered as a member of a domestic partnership within the last six months; and
- We are financially interdependent, and submit proof evidencing our financial interdependence with at least two (2) of the following:

☐ A joint bank account.

☐ A joint credit card.

☐ Joint obligors on a loan.

☐ A jointly owned residence.

☐ A jointly owned motor vehicle.

☐ Wills naming each other as executor and/or beneficiary.

☐ Having conferred upon each other authority to make healthcare decisions (e.g., healthcare power of attorney)

☐ At least one of us having designated the other as beneficiary under a life insurance policy.

☐ At least one of us having designated the other as beneficiary under a retirement benefits account.

☐ Having granted each other durable powers of attorney.

☐ We are Registered NV Domestic Patners.

We understand that any falsification of registration requirements may result in termination of Culinary Health Fund benefits for both parties; and We agree to notify the Culinary Health Fund upon the ending of the Domestic Partner status. In addition, we received the tax bulletin explaining the value of this benefit, and that it is taxable. To terminate this domestic partner dependent status, both partners must complete a termination request.

Signed this _____ day of _____, 20 _____ under the penalties of perjury.

_____	_____
Fund Participant (Print Name)	Fund Participant (Print Name)
_____	_____
Social Security #	Social Security #
_____	_____
Domestic Partner (Print Name)	Domestic Partner (Signature)

I have reviewed the items of proof as specified above and have made copies of the same.

_____	_____
Fund Representative	Date

Sworn to before me this _____ day of _____, 20 _____.

(Seal)

_____
Notary Public

My Commission Expires: _____