AFFIDAVIT FOR DOMESTIC PARTNERS COVERAGE

HOTEL EMPLOYEES AND RESTAURANT EMPLOYEES INTERNATIONAL UNION WELFARE FUND 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 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 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 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 (Signature)

_____ _____
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 same.

_____ _____
Fund Representative Date

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

(SEAL)

_____
Notary Public

My Commission expires _____