EQUITY-LEAGUE PENSION AND HEALTH FUND AFFIDAVIT OF DOMESTIC PARTNERSHIP

STATE OF )
:SS.
COUNTY OF )

I am submitting this application to (check one or both):

☐ enroll my domestic partner in health coverage

☐ designate my domestic partner to be eligible to receive a survivor annuity in the case of my death prior to retirement

1. The undersigned, being duly sworn, depose and declare as follows:

2. We are both eighteen years of age or older.

3. We are not related by blood in a manner that would bar marriage under the laws of the State in which we reside.

4. We have an exclusive close and committed personal relationship.

5. We have been living together on a continuous basis for six months prior to the date of this affidavit and intend to live together indefinitely, or were legally married in a state or country legalizing same-sex marriage.

6. *We began living together on a continuous basis on* _____.

7. *Please check which applies.*

☐ We have registered as domestic partners in our state or municipality (and we have attached a copy of our registration).

☐ We were legally married in a jurisdiction which legalizes same sex-marriage.

***OR***

☐ We live in _____ (city), _____ (state), where there is no domestic partner registry available (and we have attached a completed Declaration of Interdependence with two items of proof).

8. We are financially dependent on each other.

9. Neither of us is married (to anyone other than each other). (We understand that someone who is legally separated is still considered married.

10. We agree to notify the Equity-League Pension and/or Health Fund if there is any change in the information attested to in this affidavit.

11. We understand that disciplinary and/or civil action may be brought against one or both of us for any losses incurred by the Plan due to any false or misleading statement contained in this Affidavit, or due to our failure to notify the Plan Administrator of the termination of our domestic partnership.

12. We understand that we will be individually and jointly responsible to reimburse the Plan for any and all costs incurred by the Plan in connection with the extension of domestic partner coverage due to any false or misleading statement contained in this Affidavit, or due to our failure to notify the Plan Administrator of the termination of our domestic partnership.

_____ _____

Print Name Print Name

_____ _____

Signature Signature

Sworn to before me this
day of , 20__.

_____

NOTARY PUBLIC