Important Notice: You should seek legal advice before signing this affidavit to ensure that you understand the possible legal effects of this acknowledgment of an Equal Partner relationship.

Affidavit of Declaration of Financial Interdependence
Equal Partner Eligibility Status

This affidavit must be completed by both the employee and the declared Equal Partner. The affidavit must be notarized before submitting it to your employer.

Section 1. Domestic Partnership Requirements

Employee Name (please print): _____
Name of Equal Partner (please print): _____
Address of Employee and Equal Partner: _____
Equal Partner's Social Security Number: _____

In accordance with City Council Motion (item #201200655) adopted May, 2, 2012, an Equal Partner (and children) is eligible for insurance coverage under the City of Cincinnati health plan.

We certify that:

1. neither of us are currently married to or legally separated from another person under statutory or common law; and
2. we share responsibility for each others' common welfare; and
3. we are not related by blood in a manner that would bar our marriage in the State of Ohio; and
4. we are both at least eighteen (18) years of age and mentally competent to consent to contract; and
5. we share the same residence; and
6. we have been in an exclusive relationship with each other for at least 6 months with the intention of remaining in the relationship indefinitely; and
7. we are financially interdependent to each other as demonstrated by a signed declaration of financial interdependence and have provided the City proof of at least four (4) of the following:
    - Joint ownership of real estate property or joint tenancy on a residential lease; or
    - Joint ownership of an automobile; or
    - Joint bank or credit account; or
    - Joint liabilities (e.g., credit cards or loans); or
    - A will designating the eligible Equal Partner as primary beneficiary; or
    - A retirement plan or life insurance policy beneficiary designation form designating the eligible Equal Partner as primary beneficiary; or
    - A durable power of attorney signed to the effect that the employee and eligible Equal Partner have granted powers to one another.

Section 2. Declaration of Equal Partner

I declare that the statements in Section 1 are true and correct. I have read and understand the terms and conditions contained in this affidavit. I understand that any misrepresentation of fact in this affidavit may result in any or all of the following actions by the City of Cincinnati: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible Equal Partners; and/or 4) civil and/or criminal prosecution. Coverage ends when the equal partnership ends. You must report the termination of the partnership. If you do not do so, and obtain insurance benefit payments thereafter, you will be required to repay such benefits in full.

(1) Employee Signature: _____ Date: _____

State of _____ County of _____

Sworn to and subscribed in my presence this _____ day of _____, 20__.

_____

SIGNATURE AND SEAL OF NOTARY PUBLIC

I declare that the statements in Section 1 are true and correct. I have read and understand the terms and conditions contained in the affidavit. I understand that any misrepresentation of fact in this affidavit can result in loss of coverage and responsibility to repay in full any insurance benefit payments made in reliance on such misrepresentation or fact. Coverage ends when the domestic partnership ends. You must report the termination of the partnership. If you do not do so, and obtain insurance benefit payments thereafter, you will be required to repay such benefits in full.

(2) Domestic Partner Signature: _____ Date _____

State of _____ County of _____

Sworn to and subscribed in my presence this _____ day of _____, 20__.

_____

SIGNATURE AND SEAL OF NOTARY PUBLIC

(3) Additional Information (if necessary)

_____
_____
_____
_____
_____