CITY OF MISSOULA HEALTH BENEFIT PLAN

Declaration of Domestic Partnership

We, _____, employee, and _____, domestic partner, each certify and declare under penalty of perjury that we are each other's sole domestic partners as set out below.

a.) We are both adults who are over the age of 18 and each have the capacity to enter into a contract.
b.) We share and have shared a common residence for at least the last twelve (12) consecutive months.
c.) Neither of us is married to, or legally separated from another person.
d.) Employee has no other domestic partner under this plan.
e.) We are not legally related as siblings, parents, aunts, uncles or first cousins.

We agree to notify the Human Resources or the Plan Administrator within sixty (60) days of the termination of our domestic partnership under the criteria listed above. We understand that termination of domestic partner and dependents of domestic partner benefits coverage will be effective on the date that the domestic partnership ends.

We understand and acknowledge that this Declaration may have legal implications including taxability of benefits provided and that the Employer has advised us to consult an attorney regarding legal consequences of signing this Declaration.

I wish to enroll: ☐ **my partner**

☐ **my partner and dependent children of my partner**

The person(s) I wish to enroll qualify as my tax dependent(s) under (152) of the Internal Revenue Code:

☐ **YES** ☐ **NO**

Employee Signature: _____ Date: _____

Domestic Partner Signature: _____ Date: _____

State of Montana

County of _____

SUBSCRIBED AND SWORN to before me this _____day of _____

_____
NOTARY Signature

[Montana notaries must complete the following, if not part of stamp]

_____
(Printed Name of Notary Public)

Notary Public for the State of _____

Residing at: _____

(Affix Notarial Stamp above) My commission expires: _____

Revised 1/27/2021