

MOUNT HOLYOKE COLLEGE

AFFIDAVIT OF SAME-SEX DOMESTIC PARTNERSHIP

I. DECLARATION

We, _____ and _____ certify
Employee (print) Same-sex domestic partner (print)

that we are same-sex domestic partners in accordance with the following criteria and eligible for qualified benefits coverage as same-sex domestic partners under Mount Holyoke College's benefit program:

II. STATUS

1. We are each other's sole same-sex domestic partner and intend to remain so.
2. We are the same sex and neither one of us is legally married to anyone.
3. We are at least eighteen (18) years of age and mentally competent to enter into a contract.
4. We are not related to each other by blood in a way which would bar marriage in the state in which we legally reside.
5. We reside together in the same residence and intend to do so and/or have been certified and registered as a same-sex domestic partner in one of the cities, towns or states doing same and/or have mutual power of attorney.
6. We are jointly responsible for each other's common welfare and share financial obligations.
7. We understand that as same-sex domestic partners we are subject to the same notice requirements set forth in Mount Holyoke College's benefits programs. Mount Holyoke College must be notified within thirty (30) days of any change in our status for proper enrollment/application for/addition to College-sponsored benefit programs.

III. CHANGE IN DOMESTIC PARTNERSHIP

8. It is incumbent upon the Mount Holyoke College employee to notify the Benefits Department of any change in status as same-sex domestic partners as stipulated by the benefits contracts in force at that time. If the change in status is a termination of same-sex domestic partnership, a "Statement of Termination" shall be completed affirming that the same-sex domestic partnership status is terminated as of its date of execution and that a copy of the "Statement of Termination" has been mailed to the former same-sex domestic partner.
9. Eligibility for all benefits extended to same-sex domestic partners and dependents will cease as of the date of execution of the "Statement of Termination."
10. After such termination, I, _____ understand that a
(Employee)

subsequent "Affidavit of Same-Sex Domestic Partnership" cannot be filed until four (4) months after a "Statement of Termination" has been filed with the Mount Holyoke College Benefits Department. (The four (4) month waiting period will be waived if another Affidavit is filed for the same-sex domestic partner within thirty (30) days following the filing date of the "Statement of Termination" or in the case of the death of the same-sex domestic partner.)

IV. ACKNOWLEDGEMENTS

11. We understand that any person/employer/company who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us to recover their losses, including reasonable attorney's fees and agree to indemnify and hold harmless any person/employer/company involved in such action.
12. We understand that the employee's same-sex domestic partner and/or dependents of him/her are eligible for continuation of coverage under COBRA if they were covered by the plan prior to the "Statement of Termination."
13. If at any time it is determined that any information in this Affidavit is not true or that the same-sex domestic partner relationship has changed such that the partnership no longer meets the status criteria outlined in 1 through 7 in this Affidavit, status as same-sex domestic partners and all benefits extended to either the same-sex domestic partner or his/her dependents will cease.
14. We affirm, under the penalties of perjury, that the assertions in this Affidavit are true to the best of our knowledge.

Employee Signature

Date

Employee Address

Same-Sex Domestic Partner Signature

Date

Same-Sex Domestic Partner Address

Commonwealth of Massachusetts
County of Hampshire

On this _____ day of _____, 20____, before me, _____, the undersigned Notary Public, personally appeared _____, who proved to me through satisfactory evidence of identity, which was _____, to be the person(s) whose name(s) was/were signed on this document in my presence, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of his/her/their knowledge and belief.

Notary Public
My Commission Expires on _____