THE RESEARCH FOUNDATION
The State University of New York

Benefit Plan Affidavit of Domestic Partnership

STATE OF)
SS:
COUNTY OF)

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

We are both eighteen years of age or older and unmarried. If either or both of us have been married, we submit evidence of the termination of the marriage.

We are not related by blood in a manner that would bar marriage under the laws of the State of New York. We are each other's sole domestic partner, have been so for at least one year prior to the date of this affidavit, and intend to remain so indefinitely. We are in a relationship of mutual support, caring, and commitment, and have assumed responsibility for each other's welfare.

We have been living together on a continuous basis for at least one year prior to the date of this affidavit. (See "Proof of One Year Residency" form.)

One of us is enrolled in the Research Foundation Health Insurance Program.

Neither of us has been registered as a member of another domestic partnership within the last year.

I, the enrollee, affirm that I will file a "Termination of Domestic Partnership" form within 14 days of the date I or my partner no longer meets one or more of the qualifying criteria set forth above.

I, the enrollee, understand that any false or misleading statement made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my partner and potential disciplinary action by my employer.

_____	_____
Name (Enrollee)	*Name (Partner)*
_____	_____
Social Security Number	*Social Security Number/Date of Birth*
_____	_____
Address	*Address*
_____	_____
Address	*Address*
_____	_____
Signature	*Signature*

Sworn to before me this day of _____.
Date

_____
Notary Public