**AFFIDAVIT OF DOMESTIC PARTNERSHIP DECLARATION**

We certify that _____ is the Domestic Partner of
Domestic Partner's name (please print)

_____ in accordance with the following eligibility criteria:
Employee's name (please print)

**Domestic Partners**
Employees may enroll a same-sex or opposite sex domestic partner for coverage under the Company's plans if the employee and his/her partner meet the following requirements:

- Be at least 18 years of age and mentally competent to consent to the contract,
- Not to be legally married to or legally separated from anyone else nor have had another domestic partner within the prior 24 months,
- Intend to remain each other's sole domestic partner indefinitely,
- Live together in the same principal residence for at least 12 months and intend to do so indefinitely,
- Be engaged in a committed relationship of mutual caring and support and are jointly responsible for each other's common welfare and living expenses,
- Not be related by blood closer than would prohibit marriage in the state the employee lives in, and
- Demonstrate their interdependence by at least 3 of the following:
    - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in policy,
    - Common ownership of a motor vehicle, o Driver's license or passport listing a common address,
    - Same automobile insurance policy, o Joint bank accounts or credit accounts,
    - Designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will, Assignment of a durable property power of attorney or healthcare power of attorney.

ACKNOWLEDGEMENTS

1. We have provided the information in this Affidavit for the sole purpose of determining our eligibility for Domestic Partnership benefits.
2. We further understand that any false or misleading statements made in order to receive benefits for which we do not qualify may subject the Employee to disciplinary action.

_____ _____
(Signature of Employee) (Signature of Domestic Partner)

_____ _____
(Employee's Social Security Number) (Domestic Partner's Social Security Number)

_____ _____
(Employee's Date of Birth) MM/DD/YYYY (Domestic Partner's Date of Birth) MM/DD/YYYY

_____
Street Address City State Zip

State of _____ **:** County of _____ **:**

Signed and sworn to (or affirmed) before me on_____, 20_____,

by: _____

_____
My commission expires: _____/_____/_____ Signature of notarial officer

You may fax the documentation to 888-892-6045 or mail to Smith's Benefits Service Center, P.O. Box 9920 Providence, RI 02940-4020. All Dependent Verification documents must be submitted within 30 days of enrollment and will not be returned. Failure to provide approved verification of eligibility will default to no coverage for your dependent(s).