Revised March 10, 2004

STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN

DOMESTIC PARTNERSHIP INFORMATION AND DEPENDENT ENROLLMENT MATERIALS

Introduction

SWSCHP's governing body has approved "domestic partner" health coverage for life partners of eligible employees of SWSCHP's participating school districts. The motivation for this decision is to make family health coverage available for employees who have *committed* and *financially interdependent* relationships with their life partners, but for whom marriage is not available as an option, either for legal reasons or for reasons of personal choice. Coverage is available for "**domestic partners**" of "**eligible employees**" as provided herein.

Definitions

An **"eligible employee"** is an employee of a participating SWSCHP school district who qualifies in his/her school district for health and hospitalization coverage, whether as an active employee or as a retiree. An **eligible employee** is subject to all requirements of the participating school district with respect to full-time or part-time employment status, waiting periods, employee contributions to health and hospitalization premiums, etc.

A **"domestic partner"** is a person with whom an **eligible employee** shares a residence, and whose relationship with the **eligible employee** manifests the essential aspects of commitment, permanence, and financial interdependence of a **marriage**. A person who is under the age of 18, or whose blood relationship to the **eligible employee** is such that two persons in the same degree of consanguinity would not be permitted to marry as a matter of law, will not be considered to be a "domestic partner." A person will not be considered to be a "domestic partner" if that person, or the **eligible employee**, is (i) a party to an existing **marriage**, or (ii) is a **registered domestic partner** of (or who has otherwise declared **domestic** partner status with) another person. Furthermore, a person will not be considered to be a "domestic partner" where the sole purpose of his/her relationship to the **eligible employee** is to obtain health benefits coverage.

"Marriage" and **"married"** refer to relationships which are registered as such under the laws of any state in the United States, or the laws of a foreign country, which are recognized as **marriages** under the laws of the State of New York. To the extent that two persons of the same sex have been **married** in a state which recognizes same-sex **marriage** on the same basis as any other **marriage**, then those two persons will be considered to be **married**, and do not have to qualify as **domestic partners** in order to enroll for family health coverage.

"Registered domestic partner" means a person who, with the **eligible employee**, has registered a formal declaration of domestic partnership (or the equivalent) with a state or local government which has made provision for such registration.

"Tax dependent" means a **domestic partner** who qualifies as an **eligible employee's** dependent for federal income tax purposes, as may from time to time be defined under the Internal Revenue Code. At present, a **domestic partner** may qualify as an **eligible employee's tax dependent** if the **domestic partner** receives more than one-half of his/her support during the calendar year from the **eligible employee**, and if the **domestic partner** resides, as his/her principal residence, in the **eligible employee's** home for the entire calendar year.

"Financial Interdependence" means documentation satisfactory to SWSCHP showing that the relationship between the **eligible employee** and his/her **domestic partner** acknowledges their mutual responsibility for their mutual debts, and also meets at least **four** of the following criteria:

- A joint bank account with a sufficient regular balance to meet the parties' ordinary living expenses;
- Partner has been beneficiary of the employee's ERS or TRS retirement plan for at least 12 months
- Joint credit or debit card accounts which are used on a regular basis to meet the parties' ordinary living expenses;
- Joint obligation on a loan;
- Joint ownership of the property in which the parties reside, or joint tenancy on a residential lease, or joint payment of residential rent;
- Joint payment of common household expenses such as groceries, utilities and telephone bills;
- Joint ownership of motor vehicles or other major items of personal property;
- Joint investment accounts with significant regular balances;
- Wills which designate the parties as each other's beneficiaries and/or executors;
- Designation of each party as the other's beneficiary on a life insurance policy;
- Reciprocal designations of each other as attorney-in-fact under a durable power of attorney, or as reciprocal health care proxies;
- Status of the **domestic partner** as an authorized signatory on the **eligible employee's** bank account, credit card, or debit card;

- Designation of one party as a beneficiary of the other's benefits from the United States or a state government;

- Joint adoption of a child, or other satisfactory proof that the parties have assumed enforceable joint obligations for the care and education of a child;

- An affidavit from a creditor or disinterested third party sufficient to give proof of the parties' **financial interdependence**;

- Other documentation satisfactory to SWSCHP sufficient to give proof of the parties' **financial interdependence**.

"SWSCHP" is the State-Wide Schools Cooperative Health Plan.

Eligible Domestic Partners

An **eligible employee** may enroll a **domestic partner** for family health coverage upon meeting either **one of the two following sets** of requirements:

Requirement 1:

1. The **eligible employee** and his/her **domestic partner** are **registered domestic partners** and provide proof of the registrations document; and

2. The **eligible employee** and his/her **domestic partner** sign and submit the **SWSCHP** Certification of Domestic Partnership annexed hereto as Attachment A; and

3. The **eligible employee** and his/her **domestic partner** provide satisfactory proof of at least **four** aspects of **financial interdependence** as defined above.

4. The **eligible employee** must complete all required enrollment forms for enrollment in the **SWSCHP** Plan.

Requirement 2:

1. The **eligible employee** and his/her **domestic partner** certify that they have resided together for a minimum period of **twelve months** prior to requesting family coverage; and

2. The **eligible employee** and his/her **domestic partner** sign and submit the **SWSCHP** Certification of Domestic Partnership annexed hereto as Attachment A; and

3. The **eligible employee** and his/her **domestic partner** provide satisfactory proof of at least **four** aspects of **financial interdependence** as defined above *and* such proof demonstrates their **financial interdependence** for a minimum period of **twelve months** prior to requesting family coverage.

4. The **eligible employee** must complete all required enrollment forms for

enrollment in the **SWSCHP** Plan.

Changes in Coverage

A **domestic partner** will be dropped from family coverage (subject to any applicable continuation rights provided pursuant to COBRA or other applicable federal or state law, as the same would be applicable to a divorced spouse) if the **eligible employee** so directs. Such a direction from the **eligible employee** will be deemed conclusive and binding on the **domestic partner**, **SWSCHP**, and the **eligible employee's** employer.

A **domestic partner** will be dropped from family coverage (subject to any applicable continuation rights provided pursuant to COBRA or other applicable federal or state law, as the same would be applicable to a divorced spouse) at such time as a termination statement (or equivalent) is filed with the state or local government with which the parties have previously filed as **registered domestic partners**.

When a **domestic partner's** enrollment in family health coverage has been terminated, the **eligible employee** will not be permitted to enroll a different person as his/her **domestic partner** for a minimum period of **twelve months** following such termination. This re-enrollment restriction does not apply in the case of the death of a **domestic partner**.

At the termination of a **domestic partner's** status, the **eligible employee** should complete the **SWSCHP** Termination of Domestic Partnership form annexed hereto as Attachment B.

Children

Children of **domestic partners** who have qualified for family coverage will be eligible for health and hospitalization coverage on the same basis as children of an employee and his/her spouse.

Plan Limitations and Medicare

The enrollment of a **domestic partner** is subject to all generally applicable provisions of the **SWSCHP** Plan Document, and may be subject to additional restrictions imposed by federal law and/or regulations with respect to Medicare coverage for domestic partners.

Tax Considerations

The Internal Revenue Code provides that group health benefits provided to an employee, the employee's spouse and the employee's dependents are not subject to tax. However, employer-

provided group health benefits made available to a **domestic partner** are taxable income to the **eligible employee** unless the **domestic partner** qualifies as a **tax dependent**.

Unless a **domestic partner** qualifies as an **eligible employee's tax dependent**, the portion of health and hospitalization premium attributable to family coverage which is paid by the **eligible employee's** employer is treated as taxable income to the **eligible employee.**

In addition, where a **domestic partner** is not a qualified **tax dependent,** an **eligible employee** may not pay the employee portion of premium for his/her **domestic partner's** coverage with pre-tax dollars even where the **eligible employee's** employer has adopted a pre-tax health premium "cafeteria" plan pursuant to Section 125 of the Internal Revenue Code.

A **domestic partner** will not be considered to be a **tax dependent** unless the **eligible employee** and the **domestic partner** have completed the **SWSCHP** Domestic Partnership Tax Status Certification annexed hereto as Exhibit C. The Tax Status Certification should be re-certified on an annual basis. If there is any change in a **domestic partner's** tax status, the **eligible employee** must notify his/her employer immediately.

An employee who is unsure whether a partner qualifies as a dependent for tax purposes should consult his/her personal tax advisor.

Legal Liability Considerations

By requesting coverage, an **eligible employee** and his/her **domestic partner** are obtaining money from a public employer in reliance on the truth of their joint representations that they meet the requirements for **domestic partner** health coverage. False statements made for the purpose of obtaining **domestic partner** health coverage can result in both civil and criminal liability.

False statements made to obtain or continue **domestic partner** coverage may result in the commencement of legal action against the **eligible employee** and/or the **domestic partner** to recover any financial losses on the part of **SWSCHP** and/or the **eligible employee's** employer, including reasonable attorneys' fees. In addition, it may be a basis for disciplinary action against the **eligible employee**, including but not limited to termination of employment.

ATTACHMENT A

STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN
CERTIFICATION OF DOMESTIC PARTNERSHIP

The undersigned, for the express purpose of obtaining "domestic partner" health and hospitalization coverage from a public employer in the State of New York, as provided by the State-Wide Schools Cooperative Health Plan, certify as follows under penalty of perjury:

1. We are both eighteen years of age or older, and neither of us is a party to an existing marriage or to an existing registered domestic partnership with any third person. We are not related by blood in a manner such that two persons in the same degree of consanguinity would not be permitted to marry as a matter of law in the State of New York.

2. ***Both partners should check and initial either "A" or "B" below:***

☐ A. We share a common residence and were formally registered as domestic partners (or the equivalent) in the following government registry [*identify state, county or local office of registration and provide proof of the Registration Document*]: _____, on [*date*]: _____, 200__.

Initial: _____ Initial: _____

- or -

☐ B. We share a common residence, and have done so for at least **twelve months** prior to the date of this Certification.

Initial: _____ Initial: _____

3. We declare that we have a committed relationship which includes mutual responsibility for each other and for our mutual debts; and that we have not entered into this relationship for the sole purpose of obtaining health benefits.

4. We certify that the **four proofs** of financial interdependence identified below, and which we are submitting together with this Certification, are true and accurate [*check at least **four** boxes below and attach documentation as directed*]:

☐ A joint bank account with a sufficient regular balance to meet the parties' ordinary living expenses [*attach a copy of a recent bank statement*];

☐ Joint credit or debit card accounts which are used on a regular basis to meet the parties' ordinary living expenses [*attach a copy of a recent credit card bill*];

☐ Joint obligation on a loan [*attach a copy of a recent note or payment coupon*];

☐ Joint ownership of the property in which the parties reside, or joint tenancy on a residential lease, or joint payment of residential rent [*attach a copy of a deed, a lease, or other documentation of joint ownership or joint tenancy*];

☐ Joint payment of common household expenses such as groceries, utilities and telephone bills [*attach copies of appropriate documentation*];

☐ Joint ownership of motor vehicles or other major items of personal property [*attach a copy of title or registration*];

☐ Joint investment accounts with significant regular balances [*attach a copy of a recent account statement*];

☐ Wills which designate the parties as each other's beneficiaries and/or executors [*attach a copy of will(s)*];

☐ Designation of each party as the other's beneficiary on a life insurance policy [*attach a copy of insurance policy(ies)*];

☐ Reciprocal designations of each other as attorney-in-fact under a durable power of attorney, or as reciprocal health care proxies [*attach a copy of power of attorney or health care proxy*];

☐ Status of the **domestic partner** as an authorized signatory on the **eligible employee's** bank account, credit card, or debit card [*attach proof*];

☐ Designation of one party as a beneficiary of the other's benefits from the United States or a state government [*attach a copy of beneficiary designation form*];

☐ Joint adoption of a child, or other satisfactory proof that the parties have assumed enforceable joint obligations for the care and education of a child [*attach a copy of adoption papers or other proof*];

☐ An affidavit from a creditor or disinterested third party sufficient to give proof of the parties' **financial interdependence** [*attach original affidavit*];

☐ Other documentation satisfactory to SWSCHP sufficient to give proof of the parties' **financial interdependence**, as follows [*describe and attach*]:

_____

_____

5. We understand that the dependent children of a **domestic partner** of an **eligible employee** who have not been legally adopted by the **eligible employee** are eligible for coverage only while they are (a) unmarried, and not the domestic partner of any other person; (b) primarily dependent upon the **eligible employee** for support; (c) living with the **eligible employee** in a parent-child relationship; (d) within the age and school requirements of the **SWSCHP** Plan; and (e) not covered by the health and hospitalization coverage of another person which is considered to be primary insurance by law or by the terms of the **SWSCHP** Plan.

6. The **domestic partner** expressly understands and agrees that, if and when the **eligible employee** directs that the **domestic partner** be dropped from family coverage, such a direction will be deemed conclusive and binding on the **domestic partner**, **SWSCHP**, and the **eligible employee's** employer.

7. We have read, understand, and agree to the **SWSCHP** Domestic Partnership Information and Dependent Enrollment Materials which are attached to this Certification. We accept the terms and continuing obligations on our part which are described in those Materials.

8. We understand that we will be obtaining a benefit paid for at least in part with public funds, and that a fraudulent or false statement on either of our parts in this Certification may lead to civil and criminal liability. We agree that in the event that **SWSCHP** or the **eligible employee's** employer recover a judgment against one or both of us arising from a false statement made by one or both of us in this certification or any subsequent certification furnished to **SWSCHP** or the **eligible employee's** employer in connection with family coverage for the **domestic partner** or a child of the **domestic partner**, then **SWSCHP** or the **eligible employee's** employer, as the case may be, shall be entitled to recover its reasonable attorneys' fees from the judgment debtor in addition to any other relief which may be granted.

IN WITNESS WHEREOF we have hereunto set out hands the ___ day of _____, 200__.

_____	_____
Signature of Employee	*Signature of **Domestic Partner***
_____	_____
*Printed Name of **Employee***	*Printed Name of **Domestic Partner***

PLEASE NOTE: BOTH SIGNATURES *MUST* BE NOTARIZED ON NEXT PAGE

STATE OF _____)
} ss.:
COUNTY OF _____)

On the __ day of _____, 200_, before me came _____, to me
*Name of **Employee***
known, and known to me to be the individual described in, and who executed the foregoing Certification of Domestic Partnership, and duly acknowledged to me that he/she executed the same.

_____
Notary Public

STATE OF _____)
} ss.:
COUNTY OF _____)

On the __ day of _____, 200_, before me came _____, to me
*Name of **Domestic Partner***
known, and known to me to be the individual described in, and who executed the foregoing Certification of Domestic Partnership, and duly acknowledged to me that he/she executed the same.

_____
Notary Public

ATTACHMENT B

STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN
TERMINATION OF DOMESTIC PARTNERSHIP

I, _____ [*print name of **eligible employee***], hereby certify and declare that _____ [*print name of former **domestic partner***] and I are no longer domestic partners as of _____, 200__. I understand that except as provided with respect to continuation rights, any family health and hospitalization coverage for my former **domestic partner** will terminate as of the date of this Termination Statement.

I make and file this Termination Statement in order to cancel the Certification of Domestic Partnership heretofore filed by me and my former **domestic partner** in order to obtain **domestic partner** health benefits from **SWSCHP**.

This Termination Statement is filed because of the following [*check all applicable boxes*]:

- ☐ Formal termination of domestic partnership;
- ☐ Parties no longer reside together;
- ☐ One party has married, or become the domestic partner of, another person;
- ☐ The parties are no longer jointly responsible for each other's common welfare and living expenses.
- ☐ Death of **domestic partner**.

I understand that I cannot file another Certification of Domestic Partnership for **SWSCHP** health coverage for **twelve months** after the date of this Termination Statement unless the termination is due to the death of my **domestic partner**. In the event that the termination is for a reason ***other*** than the death of my **domestic partner**, I certify that I will mail a copy of this Termination Statement to my former **domestic partner** at the name and address below:

_____
_____
_____
_____

Date: _____, 200__

_____
*Signature of **Employee***

ATTACHMENT C

STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN
TAX STATUS CERTIFICATION

COMPLETE THIS CERTIFICATION ONLY IF IT IS ACCURATE.

IF YOU DO NOT COMPLETE THIS CERTIFICATION, THEN THE EMPLOYER-PAID PORTION OF PREMIUM ATTRIBUTABLE TO FAMILY HEALTH AND HOSPITALIZATION COVERAGE WILL BE TREATED AS TAXABLE INCOME, AND YOU WILL NOT BE ELIGIBLE TO HAVE THE EMPLOYEE PORTION OF PREMIUM ATTRIBUTABLE TO FAMILY HEALTH AND HOSPITALIZATION COVERAGE TREATED AS A PRE-TAX SALARY REDUCTION.

STATE OF _____)
} ss.:
COUNTY OF _____)

I hereby certify, under penalty of perjury that _____
*Name of **Domestic Partner***
is my "dependent" as that term is used in Section 152 of the Internal Revenue Code of 1956, as amended.

_____
*Signature of **Employee***

Sworn to before me this

___ day of _____, 200__

_____
Notary Public