LAW ENFORCEMENT OFFICERS AND FIREFIGHTERS HEALTH & WELFARE TRUST

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DOMESTIC PARTNER REQUIREMENTS – LEOFF TRUST

Domestic Partners must be approved by your local bargaining agreement. Domestic Partners are defined as two adults, of the same or opposite sex, engaged in a spouse-like relationship that has lived together for a period of not less than six (6) months. To qualify for domestic partner coverage, both individuals must meet the following qualifications.

1. Be at least eighteen (18) years of age;
2. Are responsible for each other's welfare and are each other's sole domestic partners;
3. Have jointly shared the same regular and permanent residence for at least six months immediately preceding the date the Affidavit of Domestic Partnership is signed and submitted to the LEOFF Trust;
4. Individuals are not married to or legally separated from anyone else;
5. Individuals are not related by blood to a degree that would prohibit legal marriage in the state in which they reside;
6. Individuals are engaged in a committed relationship and are jointly responsible for each other's common welfare and basic living expenses defined as the cost of food, shelter and any other expenses of maintain a household
7. Individuals are not in the relationship for the purpose of obtaining coverage
8. Individuals must be State Registered or if opposite sex, provide an Affidavit of Marriage/Domestic Partnership certifying that the relationship exists and provide sufficient documentation of a domestic partnership, as defined. Written verification will be requested on an annual basis.
9. All domestic partners participating in a Trust plan prior to February 1, 2010 will be grandfathered in based on their current "Declaration Partnership" affidavit. After February 1, 2010, new enrollees must provide a copy of a State Certified Registered Domestic Partner Certificate or opposite sex partners must provide an Affidavit of Marriage/Domestic Partnership Certificate.

Upon termination of a domestic partner relationship, a member must submit a signed Declaration of Termination of Domestic Partnership or state certificate of termination acknowledging that the relationship has ended within 30 days. Coverage for domestic partners will cease on the last day of the month the domestic partnership has ended.

LEOFF HEALTH & WELFARE TRUST

AFFIDAVIT OF Marriage/Domestic Partnership

I, _____ certify that:

(Subscriber Name)

Complete either

(A) for Marriage/State Certification – (B) for opposite sex domestic partnership

A.

I and _____ became State Certified Domestic Partners on

(Domestic Partner)

Date_____

B.

I, _____, submit this Affidavit of Domestic Partnership to

(Subscriber Name)

Establish _____ as my Domestic Partner (as defined below) for

(Name of Domestic Partner)

The purpose of obtaining benefit coverage that the LEOFF Health & Welfare Trust may extend to members' Domestic Partners.

I and _____ are domestic partners and we meet all the following criteria:

(Print Name of Domestic Partner)

- We are at least eighteen (18) years of age;
- Are responsible for each other's welfare and are each other's sole domestic partners;
- Have jointly shared the same regular and permanent residence for at least six months immediately preceding the date the Affidavit of Domestic Partnership is signed and submitted to the LEOFF Trust;

- Individuals are not married to or legally separated from anyone else;
- Individuals are not related by blood to a degree that would prohibit legal marriage in the state in which they reside;
- Individuals are engaged in a committed relationship and are jointly responsible for each other's common welfare and basic living expenses defined as the cost of food, shelter and any other expenses of maintain a household
- Individuals are not in the relationship for the purpose of obtaining coverage
- Individuals are State Registered or if opposite sex, provide an Affidavit of Marriage/Domestic Partnership certifying that the relationship exists and provide sufficient documentation of a domestic partnership, as defined. Written verification will be requested on an annual basis.

We hereby agree to notify the LEOFF Health and Welfare Trust if there is any change in status as domestic partners as certified in this statement that would make the domestic partner no longer eligible for Trust benefits within 30 days of such change.

We understand this information will be held confidential and subject to disclosure only upon express written authorization or if otherwise required by law.

We understand this declaration of responsibility may have legal implications under Washington State law.

We understand a civil action may be brought against me for any losses, including reasonable attorney's fees, because of a false statement contained in this affidavit.

We certify under penalty of perjury, under the laws of the State of Washington, the foregoing is true and correct.

_____	_____
Signature of Member	Signature of Domestic Partner
_____	_____
Address	Address
Date_____	Date_____

Original Document Requirements

Please submit three of the following items for verification:

Same Sex Domestic Partners – State Certified Domestic Partner Certificate or Marriage Certificate

Opposite Sex Domestic Partners – Must submit three of the following items for verification
Joint Mortgage Or Lease
Designation of domestic partner as beneficiary under a life insurance policy
Designation of domestic partner as beneficiary of retirement benefits
Designation of domestic partner as primary beneficiary in employee's will
Durable property and health care powers of attorney
Joint ownership of an automobile, joint bank account or joint credit account