State of New Hampshire
DEPARTMENT OF ADMINISTRATIVE SERVICES
Office of the Commissioner
State House Annex – Room 120
25 Capitol St.
Concord NH 03301

Donald S. Hill
Commissioner
(603)-271-3201

Karen D. Hutchins
Director of Personnel
(603) 271-3261

Employee Health Benefit Program
Affidavit of Same Sex Domestic Partnership

We, _____ *and* _____ *certify that:*
(Name of State Employee) (Name of Same Sex Domestic Partner)

1. We are of the same gender, are at least 18 years of age, and are mentally competent to consent to contract.
2. We are each other's sole Same Sex Domestic Partner and are responsible for each other's common welfare and financial obligations.
3. Neither of us is legally recognized as being married or being a common law spouse in the State of New Hampshire, nor related to each other by blood to a degree that would prohibit marriage in the State of New Hampshire.
4. Our Same Sex Domestic Partner relationship has been in existence for the past six (6) consecutive months prior to filing this Affidavit of Same Sex Domestic Partnership.
5. We share a residence.
6. We affirm that at least one of the following four (4) conditions exist (please check those that apply):

   ☐ **A.** We have at least one of the following:
   - ☐ Joint ownership of a motor vehicle
   - ☐ Joint bank account(s)
   - ☐ Joint credit card account
   - ☐ Lease for a residence identifying both partners as tenants
   - ☐ Mortgage/Joint ownership of residence.

   ☐ **B.** The employee has designated the Same Sex Domestic Partner as:
   - ☐ A beneficiary of the employee's life insurance policy;
   - ☐ A beneficiary for the death benefit payable from the employee's state retirement annuity; or
   - ☐ A primary beneficiary in his or her will.

   ☐ **C**. We have executed a "relationship contract" which obligates each of us to provide support for the other party and provides, in the event of termination of the Same Sex Domestic Partnership, for a substantially equal division of any property acquired during the relationship.

   ☐ **D.** We are married or have entered into a civil union that was legally issued by another state or country and was legally recognized by our state or country of residence at the date of issue.

7. We understand that Same Sex Domestic Partners are subject to the same enrollment window governing all other employees who are covered by or applying for benefit plan coverage. Any status changes may be subject to a thirty (30) day enrollment period limit, commencing from the date of the event.
8. We agree to notify the Division of Personnel office within thirty (30) days of the termination of our Same Sex Domestic Partnership. A written termination statement shall be provided to the Division of Personnel office, affirming that the partnership has terminated and that a copy of the termination statement has been mailed to the other partner.

9. We understand that another Affidavit of Same Sex Domestic Partnership for benefit coverage cannot be filed until six (6) months after a statement of termination of the previous partnership has been filed with the Division of Personnel office.

10. We understand that any person, employer, or company who suffers any loss because of false statements contained in this Affidavit of Same Sex Domestic Partnership may bring a civil action against us to recover their losses, including reasonable attorney fees.

11. We understand that electing Same Sex Domestic Partner benefit coverage may have legal implications, including taxability of benefits provided, and that before signing this Affidavit we should seek competent legal and accounting advice concerning such matters.

12. We understand that the information we are providing in this Affidavit shall be used by the Division of Personnel office for the sole purpose of activating our eligibility for Same Sex Domestic Partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our expressed written authorization or pursuant to a court order.

13. We affirm, under the penalty of perjury, that the assertions in this affidavit are true to the best of our knowledge.

_____ Signature of State Employee	_____ Signature of Same Sex Domestic Partner
_____ Printed Name of State Employee	_____ Printed Name of Same Sex Domestic Partner
_____-_____-_____ Social Security Number of State Employee	_____-_____-_____ Social Security Number of Same Sex Domestic Partner
_____/_____/_____ Date of Birth of State Employee	_____/_____/_____ Date of Birth of Same Sex Domestic Partner
_____/_____/_____ Date Affidavit Signed by State Employee	_____/_____/_____ Date Affidavit Signed by Same Sex Domestic Partner

State of New Hampshire
County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20___, by _____ and _____ personally known to me or proved to me on the basis of satisfactory evidence to be the persons who appeared before me. In witness whereof I hereunto set my hand and official seal.

_____
Notary Public

My Commission expires:

_____/_____/_____

SEAL

Division of Personnel Use ONLY

Received: _____/_____/_____

Reviewed on: _____/_____/_____

Reviewed by_____

Approved by_____

Effective Date of Coverage:

_____/_____/_____

Please forward the completed **ORIGINAL** Affidavit and enrollment form to: Division of Personnel, 25 Capitol St., Concord, NH 03301.