Affidavit of Domestic Partnership

*Must be completed if enrolling a domestic partner or children of a domestic partner.

I, __________________________________, submit this Affidavit of Domestic Partnership to establish ________________ ____________________ as my Domestic Partner (as defined below) for the purpose of obtaining benefits that Cheyenne Regional Medical Center may extend to employees' Domestic Partners.

1. I declare that my Domestic Partner is eligible for benefits because:
   [you must check one of these boxes].
   □ We have registered as domestic partners or entered into a civil union in __________________________ (state or municipality where registered);
   □ We meet all of the following criteria:
     o We are both at least age 18.
     o Neither of us is legally married to another person of the opposite sex or in a domestic partnership with another person.
     o We are not related by blood to a degree of closeness that would prohibit marriage.
     o We are in an exclusive, committed relationship that is intended to be permanent.
     o We share a mutual obligation of support and responsibility for each other's welfare.
     o We currently share a principal residence and we intend to do so permanently.

2. I agree to notify Cheyenne Regional Medical Center within thirty-one (31) days of any change in the circumstances attested to in this Affidavit by completing an Affidavit of Termination of Domestic Partnership.

3. I understand I may be responsible for payment of income taxes as a result of Cheyenne Regional Medical Center providing benefits to my Domestic Partner and his or her children.

4. If requested, I will provide to the Plan Administrator or designated representative documents to verify my Domestic Partner's eligibility.

5. I understand that if I commit fraud or intentionally misrepresent information in the Affidavit, it may result in any or all of the following actions by Cheyenne Regional Medical Center: a requirement that I reimburse Cheyenne Regional Medical Center for all expenses, termination of my employment, and other legal action against me.

I affirm that the assertions in this Affidavit are true to the best of my knowledge.

Signed_________________________________________ Date____________________________