2024 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.

The benefit will be for (check one of the boxes):

☐ Domestic Partner only

☐ Domestic Partner and his/her legally eligible dependents

Dependents of Domestic Partner	
Name	**Date of Birth**

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** the following criteria:

   - We are both at least 18 years of age;
   - Neither of us is legally married to another person or in a domestic partnership with another person;
   - We are not related by blood to a degree of closeness that would prohibit marriage;
   - We are in an exclusive, committed relationship that is intended to be permanent;
   - We share a mutual obligation of support and responsibility for each other's welfare; and
   - 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 in Support 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/her children.
4. If requested, I will provide 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 this Affidavit, it may result in any or all the following actions by Cheyenne Regional Medical Center:
    - A requirement that I reimburse Cheyenne Regional Medical Center for all expenses paid.
    - Termination of my employment.
    - Other legal action.

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

______________________________ ______________

Signature Date