ACTIVE **CONFIDENTIAL**

City of Los Angeles
Department of Water and Power

AFFIDAVIT OF DOMESTIC PARTNERSHIP
For Health Plan Enrollment Purposes Only

1. I _____ reside with my domestic partner
Employee Name (print)

_____ at _____
Domestic Partner's Name (print) Address, City, Zip

and we share the common necessities of life.

2. We have resided together in the same principal residence for at least twelve (12) months.

2a. We have resided together since _____.
Beginning Date

3. I affirm that the effective date of this domestic partnership is _____.
Date

4. Neither my domestic partner nor I is married to anyone else.

5. My domestic partner and I are each at least eighteen (18) years of age.

6. My domestic partner and I are not related by blood closer than would bar marriage in the State of California, and each of us is mentally competent to consent to contract.

7. Each of us is the sole domestic partner of the other and each of us is responsible for our common welfare.

8. I agree to notify the Department of Water and Power (Department) within thirty (30) calendar days of any change of circumstances attested to in this Affidavit by filing with the Department of Water and Power, Health Plans Administration Office, a Statement of Termination of domestic Partnership. Such statement of Termination shall be on a Department form provided by the Department of Water and Power, Health Plans Administration Office, and shall affirm under penalty of perjury that the partnership is terminated and that a copy of the Statement of Termination has been mailed to my former domestic partner.

9. I understand and agree that after I have filed such Statement of Termination, I cannot file another Affidavit of Domestic Partnership until twelve (12) months have elapsed.

10. I understand that if the Department suffers any loss because of a false statement contained in this Affidavit of Domestic Partnership, then the Department may bring civil action against me to recover its losses, including reasonable attorney's fees.

11. I understand and agree that I am providing the information in this Affidavit solely to allow the Department to determine my eligibility for the domestic partnership employee health plan benefits as defined by the DWP Health Plans Resolution. I understand and agree that the Department is not legally required to extend any benefits, other than benefits specifically granted

to an employee defined as a domestic partner by the City ordinance and the DWP Health Plans Resolution, as a result of my status as a domestic partner. I understand that the information provided in this Affidavit will be held confidential by the Department, but will be subject to disclosure (a) upon my express written authorization, or (b) pursuant to court order.

12. I understand that the information I am providing in this Affidavit may be used either by my domestic partner or by me as evidence of the existence of my domestic partnership relationship in subsequent legal proceedings. I understand that before signing this Affidavit, I should seek competent legal advice concerning the financial obligations I may be undertaking by signing the Affidavit.

13. I understand that I must pay income taxes on the amount of health and/or dental plan subsidy that will be paid by the Department to provide coverage for my domestic partner and/or the domestic partner's child (ren).

14. I agree that upon termination of this domestic partnership, the Department, its agents, officers, and employees are relived of any obligation to supply domestic partnership employee benefits to me under any ordinance, memorandum of understanding, or resolution, until the 12 months mentioned in No. 9 above have elapsed and until such time as another domestic partner application is submitted by me and subsequently approved by the Department.

15. I affirm, under penalty of perjury under the laws of the state of California that the assertions in this Affidavit are true to the best of my personal knowledge.

_____ _____

Signature of Employee Date

_____

Employee Number

SPECIAL NOTES:

- *By completing this form, you are only authorizing that health benefits be extended to your domestic partner, and not retirement benefits. If you would like your domestic partner to also receive retirement benefits, you must file a separate affidavit in the Retirement Office in Room 357, (213) 367-1692.*

- *Please submit a copy of your own and your domestic partner's California Driver's License or identification card. Be advised that the addresses on your respective licenses or identification cards must match one another and be the same as your address of record with the Department of Water and Power. Your Affidavit and application cannot be processed until all addresses are consistent.*