

AFFIDAVIT OF DOMESTIC PARTNERSHIP

Ensign Services, Inc.

I, _____, certify that:

1. I, _____ and _____
(Name of Employee – Print) (Name of Domestic Partner)

Reside at: _____
(Street Address)

(City, State, Zip Code & County)

2. We have resided together continuously since _____ and intend to reside together permanently.

Proof of shared residency may be documented by: (a) State Driver's License or Non-Driver ID from both parties, (b) copy of Deed/Mortgage/Lease naming both parties as co-owners or lessees or (c) other similar document.

3. We are not related by blood closer than would bar marriage in our state of residence, we are not legally married to anyone, and we are the sole partners of each other. Both persons are members of the same sex, OR one or both of the persons of opposite sex are age 62 or over.
4. We are at least eighteen (18) years of age or older, and are mentally competent to consent to contract.
5. We are in a committed and mutually exclusive relationship, jointly responsible for the other's welfare and financial obligations.
6. We understand that domestic partners are subject to the same rules, guidelines and policy provisions governing all other employees/dependents that are covered by or apply for insurance coverage.
7. We agree to notify the Employer in writing if there is any change of circumstances attested to in this Affidavit within thirty (30) days of such change.
8. Upon termination of this domestic partner relationship, a Notice of Termination of Domestic Partnership shall be filed with the Employer within 30 days. Such Notice shall affirm, under a penalty of perjury, that the domestic partner relationship is terminated and that a copy of the Notice has been mailed to the other partner.
9. After such termination, Employee understands that another Affidavit of Domestic Partnership cannot be filed until after a Notice of Termination of previous domestic partner relationship has been filed with the employer.
10. We understand that upon termination of the domestic partnership, the children of the Domestic Partner will no longer qualify as dependents of the Employees.
11. We understand that any persons/employer/company who suffers any loss because of false statement contained in an Affidavit of Domestic Partnership may bring a civil action against us to recover their losses including reasonable attorney's fees.
12. We understand that insurance coverage is subject to all terms and conditions required by the group policy of the insurance plan, and is subject to all applicable federal, state and municipal laws.
13. We understand that current State and Federal continuation or conversion coverage laws may not apply to domestic partners. Continuation coverage laws provide the right to pay for a temporary extension of health insurance if coverage would terminate due to termination of employment, reduction of hours, death of spouse, and/or divorce.

AFFIDAVIT OF DOMESTIC PARTNERSHIP (continued)

14. We understand that Employer reserves the right to make changes in plan benefits, premiums and eligibility requirements, and to make a determination that this domestic partner relationship conforms to the provisions of this Affidavit.
15. We understand and affirm, under penalty of perjury and employee disciplinary action which may result in loss of employment that the information provided on this Affidavit is accurate and complete. We understand and agree that any omissions or incorrect statements knowingly made on this Affidavit may invalidate our insurance coverage.

EMPLOYEE

Date

Signature of Employee

Date of Birth

Social Security Number

DOMESTIC PARTNER

Date

Signature of Partner

Date of Birth

Social Security Number

NOTARY (Required)

Subscribed and sworn to before me this _____ day of _____, _____

Notary Public

My commission expires _____