Domestic Partner Forms

Version: 3

Suffolk County Municipal Employee Benefit Fund
30 Orville Dr. Suite D
Bohemia, NY 11716-2513

Eligibility Division
631-319-4099 ext. 321 or 322
631-218-7970 fax

Website
www.scmebf.org

Revised and adopted on March 2, 2023

SCMEBF
STATEMENT OF DOMESTIC PARTNERSHIP

All Fields Must be Completed.

Member Information

Name: _____ Social Security #: _____

Daytime Phone: _____ Home Phone: _____

Residence Address: Gender: _____ Date of Birth: _____

Street: _____

City/State: _____ Zip Code: _____

Partner Information

Name: _____ Social Security #: _____

Daytime Phone: _____ Home Phone: _____

Residence Address: Gender: _____ Date of Birth:_____

Street: _____

City/State: _____ Zip Code: _____

Declaration

We, the undersigned _____ and _____
(Print Member's Name) (Print Partner's Name)

declare that on _____ we agreed to live as domestic partners in a
(Insert Date)

committed relationship of mutual support and caring as defined in this document, and that we have so lived since that time. We further state that since that time we have held ourselves out publicly to be each other's sole domestic partner and intend to remain in such a committed relationship for the foreseeable future. To demonstrate our status as Domestic Partners, and as proof of benefit eligibility as established by Suffolk County Municipal Employees Benefit Fund, we are duly sworn and declare to meet the specified Domestic Partner criteria and can **provide a minimum of two (2) documents from the accompanying list with at least one (1) from Section A**.

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STATEMENT OF DOMESTIC PARTNERSHIP

I, the member, affirm that I will file a **Termination of Domestic Partnership Form within 14 days of the date I / my partner no longer meets one or more of the qualifying criteria**. I also understand that any false or misleading statement made to receive benefits for which I or my Domestic Partner do not qualify will subject me to financial responsibility for any benefits paid on behalf of my partner, or his/her dependent child including a suspension of my benefits until any payments made on behalf of an ineligible dependent are fully satisfied.

Acknowledgements (The member must initial after each acknowledgement)

1. Domestic partners are subject to the same plan provisions and requirements as a spouse. ____
2. Domestic partners may only be added as a dependent while an Active Member with the Fund and cannot be added as a Retiree. ____
3. SCMEBF reserves the right to request current proof, at any time, that my partnership meets the joint residency and financial interdependence eligibility criteria, and I agree to provide SCMEBF with supporting documents. ____
4. It is our understanding that the value of the contributions made by SCMEBF towards the cost of domestic partner coverage for the provided plans is treated as taxable income to me, the member unless my domestic partner qualifies as a dependent under Internal Revenue Code 152. The same rule applies to the coverage for the dependent children of my domestic partner. However, SCMEBF will not assume any responsibility for any tax or reporting obligation that might result from me or my domestic partner from these acknowledgements. ____
5. We have provided the information in this Statement knowing the SCMEBF will be relying on the acknowledgements made in this Statement and will grant benefits to us based on such reliance. ____
6. We understand that making any false or misleading declarations and acknowledgments in this Statement of Domestic Partnership or failure to notify SCMEBF of any change in status as domestic partners could result in the SCMEBF ceasing the benefits to either or both of us, and any dependent child(ren), if applicable. ____
7. We understand that SCMEBF rules on domestic partners may be revised or amended by the Fund at any time and that our continued coverage will be subject to those changes. ____
8. We understand that we must comply with the SCMEBF's annual re-enrollment for eligibility each year. ____
9. I understand that I will file a Termination of Domestic Partnership Form within 14 days of the date I / my partner are no long living together or when my Domestic Partnership no longer meets the minimum qualifications set forth by the SCME Benefit Fund. If at any time benefits are paid for my no longer eligible domestic partner, I acknowledge that I am, as the Fund member, financially responsibility to repay the SCME Benefit Fund for any benefits paid on behalf of my domestic partner, or his/her dependent child. ____

SCMEBF
STATEMENT OF DOMESTIC PARTNERSHIP

10. We affirm and declare under penalty of perjury that the statements made above are true and complete to the best of our knowledge. ____

Print Name: _____ (Member's Name)

Print Name: _____ (Partner's Name)

Signature: _____ (In presence of notary)

Signature: _____ (In presence of notary)

For use by Notary

State of _____)
) ss.:
County of _____)

Subscribed and sworn to (of affirmed) before me _____ day of this
(Day)

_____ (Month) , _____ (Year) , by _____ (Name of signer)

_____
(Signature of Notary)

(Seal of Notary)

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STATEMENT OF DOMESTIC PARTNERSHIP

Criteria

Domestic Partners are defined as two individuals who, together, each meet **ALL** the following criteria:

1. Are at least eighteen (18) years old, and mentally competent to consent to contract.
2. Not legally married, nor the domestic partner of any other person, during the time the subject domestic partnership existed.
3. Are not related by blood closer than permitted under marriage laws of the State of New York.
4. Have entered the domestic partner relationship voluntarily, willingly and without reservation.
5. Have entered a relationship which is the functional equivalent of a marriage, and which includes all the following:
    a. Living together as a couple
    b. Mutual support for each other
    c. Mutual caring and commitment to each other
    d. Financial interdependence
    e. Joint responsibility for necessities of life
6. Reside together as a couple in the same residence, at the same address, on a continuous basis, and have done so for at least six (6) months prior to submitting this application.
7. Have not been registered as a member of another domestic partnership within the last two (2) years prior to date of application.
8. Intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at will of either partner.

Signature Member

Signature Domestic Partner

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STATEMENT OF DOMESTIC PARTNERSHIP

Provide at least two (2) documents from the accompanying list with at least one (1) from Section A.

The documents must show financial interdependence for the period during which it is claimed that the domestic partnership existed.

Section A [Need one (1)]

- Joint obligation on a loan joint debit or credit card(s)
- Joint ownership of our residence
- Joint homeowners' insurance policy
- Joint responsibility for childcare (e.g., school documents, guardianship)
- Mutually granted durable powers of attorney
- Designation of one partner as the representative payee for the other's government benefits
- Joint ownership or holding of investments
- Joint ownership of lease of a motor vehicle
- Both listed as tenants on the lease of a shared current primary residence
- Mutually granted authority to make health care decisions (e.g., health care proxy/power of attorney)
- Share a household budget for the purpose of receiving government benefits
- Most recent Federal tax return on which my partner is claimed as a dependent for Federal tax purposes
- Designated as beneficiary under the other's life insurance policy, retirement benefits account, Will or executor of each other's Wills
- An affidavit by corporate creditor or other disinterested third-party qualified to testify to partners' financial interdependence.
- A certified Civil Union License

Section B

- Joint bank account
- Joint debit or credit card(s)
- Status as authorized signatory on the partner's bank account, debit or credit card
- Registration as Domestic Partners in a municipality that has established such a procedure (e.g., Suffolk, Nassau, New York City)
- Other acceptable proof establishing economic interdependence

***A copy of the domestic partners social security card and birth certificate is required**

All documents written in a language other than English must be accompanied by a translation, with the translator's notarized signature.

Admin Use Only
☐ **Approved** ☐ **Not Approved**
Administrator: _____ Date: _____

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SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

DOMESTIC PARTNER DEPENDENCY AFFIDAVIT

In the matter of _____, _____,
(domestic partner) (domestic partner social security number)

domestic partner of _____, _____, who
(member) (social security number)

is a member of the _____ Fund and who resides at:

_____.
(member's complete address)

STATE OF)
) ss.:
COUNTY OF)

_____, being duly sworn deposes and says, under
(name of covered member)

penalty of perjury:

(Circle 1 or 2)

1. That as stipulated in Internal Revenue Code Section 152, my domestic partner is dependent upon me for financial support and accordingly, I am permitted to list him/her as a dependent on my income tax returns for income tax purposes, as provided for in the Internal Revenue Code, and, if available, as is evidenced by my annexed income tax returns for the most recent calendar year, **OR**

2. That I make this affidavit to relieve the SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND ("Fund") from having to report the income to the County of Suffolk ("Employer") for inclusion on my W-2 form, for the value of the Fund benefits provided to my domestic partner as a result of his/her status as such. I understand that the Fund is relying on my representations herein and I agree to indemnify and hold the Fund harmless in the event any of the information contained herein is not true.

That I understand that I will be required to continue to provide proof of said dependency status, on an annual basis, to the Fund. **I understand that the Fund recommends that I consult a tax advisor to assist me in my claim that my domestic partner is my dependent for income tax purposes**

DATED: _____, 20__ _____
(signature of covered member)

Sworn to before me this

____ day of _____, 20__. _____
(Notary Public)
My Commission Expires:

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