DOMESTIC PARTNER ENROLLMENT
Instructions

Election for Domestic Partner coverage must either be done at the time of hire, at open enrollment or when you experience a qualifying event. Domestic Partner coverage is open to couples of same sex and opposite sex (and their dependent children).

The employee must **provide proof of 12 months joint residency** with the Domestic Partner. The proof should show both names and addresses (being the same); something from present and something from 12 months ago. For example, a joint checking account statement shows the date as well as the names and addresses. Even if the Domestic Partners have moved over the course of the year, it does not matter. As long as they resided together in the same residence 12 months ago and they do presently.

Domestic Partners are not viewed as Qualified Beneficiaries. If the employee were to terminate employment, the employee would be eligible for COBRA for their health, dental and/or vision coverage. The Domestic Partner, however, would not. The Internal Revenue Service (IRS) does not recognize Domestic Partners as eligible dependents under the Internal Revenue codes governing employee benefit programs. Therefore, purchased benefits are taxable income to the employee.

If during the course of the year, the couple is no longer together, it would be the employee's responsibility to notify Human Resources. The Domestic Partner would be moved from their health, dental and/or vision plan and a Certificate of Health Coverage would be sent to the ex-Domestic Partner. This also makes the employee ineligible to participate for the next 12 months.

The original Domestic Partner Form, along with the proof of joint residency, is kept in a file separate from the employee's personnel file.

STATEMENT OF SAME/OPPOSITE SEX DOMESTIC PARTNERSHIP

FOR ELIGIBILITY OF BENEFITS

DECLARATION

We _____ and _____
Employee's Name Partner's Name

certify that we are domestic partners in accordance with the following criteria and eligible for benefits coverage as domestic partners under the MAPFRE U.S.A. Corp. Benefit Program.

CRITERIA

- We are each other's sole domestic partner and intend to remain so indefinitely
- We are of the ☐ same ☐ opposite sex and neither one of us is married.
- We are at least eighteen (18) years of age and mentally competent to consent to contract.
- We are not related by blood to a degree of closeness greater than which would prohibit legal marriage in the State in which we legally reside.
- We have resided together in the same residence for at least one (1) year and intend to do so indefinitely. Proof of joint residency is attached.
- We are jointly responsible for each other's common welfare and financial obligations.
- We meet the eligibility requirements of the MAPFRE U.S.A Corp. Benefit Plan

CHANGE IN DOMESTIC PARTNERSHIP STATUS

We agree to notify MAPFRE U.S.A. Corp. if there is any change in our status as domestic partners as attested to in this affidavit which would make us no longer eligible for benefits (for example, a change I joint residence or if we are no longer each other's sole domestic partner). We will notify MAPFRE U.S.A. Corp. in writing within thirty (30) days of such change.

After such termination, I _____ (Employee's Name), understand that a subsequent Affidavit of Domestic Partnership cannot be filed until one (1) year has elapsed. (The one (1) year waiting period will be waived only if another Affidavit is filed to reinstate the same domestic partner within thirty (30) days following the effective date of the termination.)

ACKNOWLEDGMENTS

- We understand that any person/employer/company who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us to recover their losses, including reasonable attorneys' fees.
- We have provided the information in this Affidavit for use by MAPFRE U.S.A. Corp. for the sole purpose of determining our eligibility for domestic partnership benefits.
- We affirm under penalty of perjury that the assertions in this Affidavit are true to the best of our knowledge.
- We understand that any Federal and State tax impact resulting from the imputed value of the benefits provided is our sole responsibility.

SIGNATURES

_____ _____
Employee's Signature Date

_____
Employee's Address

_____ _____
Domestic Partner's Signature Date