



I. Declaration

We, _____, _____ and
“Employee” (print) Social Security #
_____, _____,
“Partner” (print) Social Security #

certify that we live together in a spouse-like relationship and are domestic partners (hereinafter a “Domestic Partner”) and are eligible for APSC medical and/or dental (hereinafter known as “health plan”) benefits, or relocation benefits (if applicable), in accordance with the following criteria:

II. Criteria

- 1. We are at least eighteen (18) years of age and mentally competent to enter into a legally binding contract.
2. Neither of us is legally married nor the Domestic Partner of anyone else.
3. We are currently residing together in the same principal residence, have done so for the last twelve months, and intend to do so indefinitely.
4. We are jointly responsible for each other’s common welfare.
5. We are jointly responsible for financial obligations of the partnership.
6. We are not related to a degree of closeness such that Alaska law would preclude us from being married to each other.

III. Change in Status

- 1. We acknowledge that, in the event we no longer meet the criteria set forth in Section II above, we will no longer be considered Domestic Partners, and the Partner will no longer be eligible for APSC health plan benefits except as provided by COBRA, if applicable. In the case where relocation benefits may have applied, the Partner will no longer be eligible for any benefits associated with this program.
2. Employee agrees to notify their business unit Human Resource office if there is any change in our status as Domestic Partners, as attested in this Affidavit, which would change our eligibility for APSC health plan benefits. For example, in the event that we cease to reside together, or if we are no longer each other’s Domestic Partner, Employee will notify, in writing, the business unit Human Resource office within thirty (30) days of such change.
3. After such change in status the Employee understands that a subsequent Affidavit of Domestic Partnership cannot be filed until twelve (12) months after notifying the business unit Human Resource office in writing of the change in status.

IV. APSC Health Plan Benefits

- 1. We understand that this Affidavit must be filed in order for a Domestic Partner to be eligible for coverage under APSC’s health plan, or relocation benefits (if applicable), and that filing this Affidavit does not enroll us for any benefits.
2. We understand that we will need to complete other enrollment procedures in order to enroll a Domestic Partner in an APSC health plan benefit for which a Domestic Partner is eligible, or to receive relocation benefits.
3. We acknowledge that filing this Affidavit does not automatically result in the naming of the Partner as beneficiary for the Employee’s welfare, retirement or any other APSC employee



Affidavit of Domestic Partnership

benefit plan. The employee must complete the appropriate beneficiary designation procedure in order for the Domestic Partner (or any other named beneficiary) to receive survivor benefits.

- 4. The Employee can drop Domestic Partner coverage for APSC health plan benefits during Open Enrollment or within 30 days of a life event as defined by APSC Summary Plan Descriptions (SPD's).

V. Acknowledgements

- 1. We certify that the information we have provided on this form is true and correct. We understand that any statements on this form which are known to be false or any material omissions by either of us may be cause for Employee disciplinary action, including but not limited to, loss of APSC health plan benefits, loss of relocation benefits, and/or termination of APSC employment.
- 2. We agree that the Employee will reimburse any person or agent of APSC for any loss (including any claim and/or premiums, or other expenses paid as a result of this Affidavit) due to any false statements contained on this Affidavit or any material omissions. Moreover, if APSC must bring civil action against either or both of us to recover its losses, the Employee agrees to pay all costs associated with the action, including reasonable attorney's fees.
- 3. We understand that the Employee and APSC contribution for health plan premiums attributable to the Domestic Partner will be considered and reported as taxable income to the Employee unless the Employee provides evidence that the Domestic Partner qualifies as a "dependent" under the Internal Revenue Code.
- 4. We understand that we are advised to seek legal and tax advice before signing this Affidavit.

Signatures:

Employee Signature

Partner Signature

Principal Residence Address

Principal Residence City, State, Zip Code

Home Telephone

Work Telephone

Date

STATE OF _____ δ

_____ δ

COUNTY OF _____ δ

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

Signature of Notary Public

My Commission Expires: _____