University of Colorado
Boulder | Colorado Springs | Denver | Anschutz Medical Campus
EMPLOYEE SERVICES

800 Grant Street, Suite 400
400 UCA
Denver, CO 80203

t 303 860 4200
f 303 860 4299
1 855 216 7740 (toll free)
e employeeservices@cu.edu

AFFIDAVIT OF DOMESTIC PARTNERSHIP

INSTRUCTIONS

1. Review and complete this Affidavit to declare the establishment or termination of a Domestic Partnership for purposes of dependent eligibility for a Domestic Partner.
2. Review, print, SIGN, and notarize this Affidavit.
3. Upload and return this signed and notarized Affidavit along with the Dependent Eligibility Verification Form and any Required Documentation to Employee Services via your employee portal.

EMPLOYEE INFORMATION

Name (Last)	(First)	(Middle Initial)	HRMS Employee ID Number

Date of Birth (mm/dd/yyyy)	Date of Employment	Campus Department	Campus Telephone

AFFIDAVIT TYPE

☐ Declaring Domestic Partnership (*Same Gender*) **Effective Date**_____
(*Opposite Gender Partners not eligible until 7-1-2018)*

☐ Terminating Domestic Partnership **Effective Date**_____

DECLARATION TO ESTABLISH DOMESTIC PARTNERSHIP

For the purpose of establishing dependent eligibility at the University of Colorado and for no other purpose, we make the following declaration.

I, _____, an employee/retiree of the University of Colorado, and my Domestic Partner, _____, hereby declare that:

1. We have an exclusive mutual commitment.
2. We are each other's sole Domestic Partner and intend to remain so indefinitely.
3. Neither of us is legally married, a Partner in a Civil Union, or a Partner in another Domestic Partnership.
4. We are at least 18 years of age and are legally competent to enter into a contract in the State of Colorado.
5. We are not related by blood to a degree of closeness, which would prohibit legal marriage in the state of Colorado.
6. We have shared a principal residence for at least twelve (12) consecutive months, intend to reside together indefinitely, and currently reside at: _____
7. We share joint responsibility for our common welfare, living expenses, and financial obligations and will provide Employee Services with adequate documentation regarding this joint responsibility.
8. If we terminate our Domestic Partnership, we will notify the University of Colorado within thirty-one (31) days by providing an Affidavit declaring the termination of our Domestic Partnership.

DECLARATION TO TERMINATE DOMESTIC PARTNERSHIP

I, _____, an employee/retiree of the University of Colorado, and my Domestic Partner, _____, hereby declare that:

1. We have terminated our Domestic Partnership.
2. We understand that termination of health, dental and/or life coverage obtained as a result of this termination will be effective on the last day of the month during which the Domestic Partnership ends or at such time as coverage terminates in accordance with the terms and conditions of applicable policies.
3. We understand that a subsequent Affidavit declaring a Domestic Partnership cannot be filed until at least twelve (12) months after the submission of this Affidavit terminating a Domestic Partnership has been received by Employee Services.

ACKNOWLEGEMENTS

1. We understand that the benefit policies, contracts, and University policies govern all questions of eligibility and coverage of Domestic Partners.
2. We understand that the University of Colorado reserves the right to modify its policy on Domestic Partners at any time.
3. We understand that making any false or misleading declarations or acknowledgements in this Affidavit or failure to timely notify the University of Colorado of the termination of the Domestic Partnership may result in disciplinary action against the University of Colorado employee.
4. We understand that this Affidavit and the receipt of benefits may create or impact legal and tax obligations, rights, duties, and/or liabilities. We acknowledge that the University of Colorado has not provided us with advice regarding these issues and the University of Colorado has advised us to seek individual legal and tax advice.
5. We understand that the information provided in this Affidavit will be treated as confidential by Employee Services but will be subject to disclosure:
    a. upon our express written authorization or
    b. if otherwise required by law.

SIGNATURE

We affirm and declare that the information in this Affidavit is true and complete to the best of our knowledge.

_____	_____	_____
Employee Signature	Employee Printed Name	Date
_____	_____	_____
Domestic Partner Signature	Domestic Partner Printed Name	Date

NOTARIZATION

State of_____ County of_____

Signed and sworn to (or affirmed) before me on_____(date) by_____

_____

Signature of notarial officer

Stamp

(_____ (Title of office)) My commission expires: _____