DOMESTIC PARTNERSHIP

A domestic partnership is a committed relationship of at least 6 months duration, between two persons, regardless of gender (neither of whom are married to anyone else), who share responsibility for the common welfare and financial obligations of each other.

Enrollment Procedures:

In order to enroll your domestic partner in the OHSU Student Group Major Medical Health Insurance Plan and/or the Student Health Service you must submit both of the following:

1. An Affidavit of Domestic Partnership (see attached).
2. Proof of cohabitation and financial interdependence for at least the past 6 months (see below).

Proof of Cohabitation and Financial Interdependence lasting at least 6 months:

Provide documentation of three of any of the following:

1. Copies of statements of not less than 5 joint accounts, including but not limited to: bank accounts, investment accounts, credit and charge cards, utility bills, and insurance policies. The statements must show both names together, not separate names at the same address.
2. Copies of driver’s licenses, car registrations, voter registration cards, insurance policies, or tax returns at the same address.
3. Copy of a fully executed living together agreement.
4. A copy of a jurisdictional domestic partnership registration.
5. A beneficiary designation form that shows your domestic partner as the beneficiary for your life insurance, retirement plan, or will.
AFFIDAVIT OF DOMESTIC PARTNERSHIP

This is a legal document with legal consequences which exceed your student relationship with Oregon Health & Science University. Some states and/or municipalities may view this document as a means of establishing property or status rights. You should consult with legal counsel before executing.

STATE OF:

COUNTY OF:

1. I, ____________________________ submit this Affidavit of Domestic Partnership to establish _____________________________ as my Domestic Partner (as defined below) for the purpose of obtaining medical insurance for my Domestic Partner.

2. I, ___________________________ declare and acknowledge that my Domestic Partner and I meet the following criteria.

   1. We currently reside together, and we intend to do so permanently.
   2. We are not related by blood to a degree of closeness that would prohibit marriage were we of the opposite sex.
   3. We are mutually responsible for basic living expenses.
   4. We are both at least the age of consent in the state in which we reside.
   5. Neither of us is married to anyone else.
   6. Neither of us is in a Domestic Partnership relationship with anyone else.
   7. We agree to immediately notify Student Health Service of any change/termination in the status of our domestic partnership.

I affirm that the statements in this Affidavit are true to the best of my knowledge:

DATED:

__________________________________________
Signature

__________________________________________
Name

__________________________________________
Address

__________________________________________
City, State, Zip Code

Sworn before me this________ day of____________________, 20_____

__________________________________________
Notary

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