

# Small Group Domestic Partnership Alternative Affidavit



Please complete and sign this Affidavit before a Notary Public and submit it to Kaiser Permanente, as applicable, if you have not registered your domestic partnership. If you have registered with your jurisdiction or municipality then you must provide proof of such domestic partnership registration to Kaiser Permanente Permanente, as indicated, along with the completed Declaration of Cohabitation and Financial Codependent form. Domestic partner benefits may have federal and state tax consequences. You should consult the applicable laws and/or a tax professional before applying to enroll your domestic partner for dependent health coverage.

The undersigned, being duly sworn, depose and declare that all of the following statements are true:

- ✓ We are both eighteen (18) years of age or older and unmarried.
- ✓ We are not related by blood in a manner that would bar marriage under the laws of the State of Colorado.
- ✓ We have a close and committed personal relationship.
- ✓ We have been living together on a continuous basis for at least twelve (12) months prior to the date of this affidavit. We have been sole Domestic Partners living together continuously since \_\_\_\_\_ (month/day/year), and we intend to remain sole Domestic Partners indefinitely.
- ✓ Neither of us has been registered as a member of another domestic partnership within the last (12) months.
- ✓ We are submitting this Affidavit and the Declaration of Cohabitation and Financial Codependent form so that Kaiser Permanente may determine whether the partner named below is eligible for dependent health benefits coverage.
- ✓ We understand that our submission of these forms does not automatically enroll us in the Kaiser Permanente health benefits program.
- ✓ We understand that, in the event we no longer meet the criteria attested to in this Affidavit and the Declaration of Cohabitation and Financial Codependent form, we will no longer be considered a domestic partnership as defined by Kaiser Permanente and the partner named below will no longer be eligible for Kaiser Permanente dependent coverage.

We certify, under penalty of perjury, that the foregoing is true and correct.

Print name of employee/Kaiser Permanente subscriber

Print name of partner

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

STATE OF Colorado

COUNTY OF \_\_\_\_\_)

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

Please return this form to Kaiser Permanente Small Business Unit by mail or fax to:

Kaiser Permanente Sales Department  
Attn.: Small Business Unit  
2530 S Parker Rd Ste. 650  
Aurora, CO 80014-1618

Fax: 303-306-2555