



## **DOMESTIC PARTNERSHIP HEALTH & WELFARE BENEFITS ELIGIBILITY**

Effective with the 7/1/2004 plan year, LBCC has expanded the Health and Welfare insurance coverage for active employees to include domestic partner eligibility. The term domestic partner refers to individuals as defined in the required, notarized Affidavit of Domestic Partnership.

### **Eligibility**

To be eligible for coverage, the domestic partner must be your “sole spousal equivalent”. You must both be adults and live together in an exclusive, committed relationship and assume joint responsibility for your basic living expenses. You must share a common residence and intend to continue to do so indefinitely. Your domestic partner must be at least eighteen years of age, unrelated to you by blood, and neither you nor your domestic partner may be married, or have another domestic partner, or have had another domestic partner at any time during the 6 months before enrolling for health care benefits. Benefits are available to same or opposite sex domestic partners. Benefits are not available for dependents of the domestic partner at this time. Domestic partners are not eligible for COBRA.

### **When Coverage Starts**

After closure of the initial annual open enrollment period in June 2004, in order to add a domestic partner, the employee will have 31 days from the date of filing a Declaration (Affidavit) of Domestic Partnership with the District’s Payroll/Benefits Office to request coverage for the domestic partner to enroll in the plan. If the request for coverage is not done within the 31 calendar day period, the employee must wait for the next open enrollment period to request coverage.

### **Cost of Coverage**

The District will make the same premium contribution for your domestic partner as for a legally married spouse and eligible dependent children. Dependents of domestic partners are not eligible, at this time.

The IRS does not recognize domestic partners as “dependents” for Federal income tax purposes. The State of California only recognizes some domestic partnerships. LBCC must report the “fair market value” of the domestic partner coverage as taxable income on the employees W-2 and withhold applicable taxes from the employee’s paycheck.

### **Other Legal Consequences**

Employees electing this benefit are advised to consult an attorney regarding the possibility that the filing of the Affidavit of Domestic Partnership may have other legal consequences, including the fact that it may, in the event of termination of the spousal equivalent relationship, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purpose of establishing and dividing community property, or for ordering payment of support.

### **When Coverage Ends**

Coverage for your domestic partner will end if:

- Your domestic partner dies; or
- The criteria for an eligible domestic partnership as defined above are no longer met.

You must notify the Long Beach Community College Payroll/Benefits Office within 31 days after either of these events. You can file a Statement of Dissolution at any time you wish to terminate coverage of your domestic partner.

You cannot file another Affidavit of Domestic Partnership for a new domestic partner until at least 6 months after you file a Statement of Dissolution. There is no waiting period required for filing a second Affidavit of Domestic Partnership for a domestic partner for whom you previously filed a Statement of Dissolution, but you must wait until the next available open enrollment period to add them back to the plans.

***Benefits for eligible domestic partners apply to medical (to include mental health), dental and vision coverage.***

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### **Enrollment Instructions**

1. Complete, sign and notarize the enclosed Affidavit of Domestic Partnership.
2. Complete the enclosed Domestic Partner Health Care Enrollment Statement and submit it along with the carrier enrollment forms. Carrier enrollment forms are available from the Benefits Office (LAC T-1026). For assistance, contact the Benefits Technician at (562) 938-4531.



## DOMESTIC PARTNER HEALTH CARE ENROLLMENT STATEMENT

To enroll \_\_\_\_\_ in the Long Beach Community  
(Name of Domestic Partner)  
College District health care plans as the Domestic Partner of \_\_\_\_\_,  
(Name of Employee)

I declare and acknowledge my understanding that:

- All group health care coverage is governed by the terms of the underlying plan(s).
- I have submitted the Affidavit of Domestic Partnership establishing that my domestic partner and I reside together and are financially interdependent.
- The District has no legal obligation to extend COBRA benefits to my domestic partner.
- I understand that the Internal Revenue Service currently treats as imputed income to the employee the value of the health care coverage provided to domestic partners.
- I have an obligation to file a Statement of Dissolution with the District within 31 days of the death of my domestic partner or the date the criteria of a domestic partner relationship listed in the Affidavit of Domestic Partnership are no longer met by me and my domestic partner.
- Regardless of whether the required Statement of Dissolution has been filed, the effective date of the end of the spousal equivalency relationship, and, therefore, the date on which coverage of my domestic partner will end according to the terms of the particular plan(s) in which they are enrolled, is the earliest of (a) the death of my domestic partner, (b) the date on which I file a Statement of Dissolution with LBCCD, or (c) when the criteria for a domestic partner relationship listed in the Affidavit of Domestic Partnership are no longer met by me and my domestic partner.
- I have submitted the Election Form required for coverage under the desired underlying plan(s), and request the coverage that I have elected be provided for myself and my domestic partner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Employee's Social Security Number

\_\_\_\_\_  
Employee's Name (please print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip



LONG BEACH  
CITY COLLEGE

## Affidavit of Domestic Partnership

### Section One

I, \_\_\_\_\_ and \_\_\_\_\_ are (print  
complete name of employee) (print complete name of domestic partner)

*(If not printed legibly, Affidavit will be rejected).*

domestic partners and we:

- are each eighteen (18) years of age or older and are capable of consenting to the domestic partnership
- share a close personal relationship and are responsible for each other's common welfare
- are each other's sole domestic partner
- are not married to anyone and do not have other domestic partners
- are not related by blood closer than would bar marriage in the state of California
- share the same regular and permanent residence, with the current intent to continue doing so indefinitely
- are jointly financially responsible for "basic living expenses", defined as the cost of basic food, shelter, and any other expenses of a domestic partner which partner qualified because of the domestic partnership. *(Note: Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost).*

### Section Two

- I understand that my domestic partner is eligible for enrollment at the time of my hire or throughout the year based on the same eligibility criteria used for other dependents.
- I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in circumstance attested to in this Affidavit.
- I agree to provide written notice to my payroll/benefits representative if there is a change of circumstances attested to in this Affidavit within 31 days of the change by filing a Statement of Termination of Domestic Partnership.

### Section Three

- We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of a willful falsification of information contained in this Affidavit of Domestic Partnership.
- We understand that under applicable federal and state income tax law, payments for health coverage of a domestic partner may result in additional imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes). Consult with your Payroll/Benefits department for information.
- We understand that, in addition to the eligibility requirements of Long Beach Community College District for domestic partner coverage, there are terms and conditions of coverage set forth in the Group Agreement of each health care plan offered through Long Beach Community College District to which we agree to be bound. We acknowledge that, depending on the health care plan we select, the applicable Group Agreement may include, for example and without limitation, (1) a requirement

that each of us arbitrate any and all claims, including malpractice claims, against the health care plan we choose and its related organizations and providers; and (2) the right of the health care plan to terminate coverage on the grounds set forth in the Group Agreement including, without limitation, termination of coverage due to fraud, and misrepresentation of eligibility. By executing this Affidavit, we agree to be bound by the terms and conditions of coverage of the health care plan selected as set forth in the applicable Group Agreement, including the arbitration clause, if any.

- We understand willful falsification of information contained in this Affidavit may result in our termination of enrollment by the health care plan that we select for coverage.

**We certify under penalty of perjury under the laws of the State of California, that the foregoing is true and accurate to the best of our knowledge. Signatures of both partners must be notarized.**

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Domestic Partner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

## NOTARIZATION REQUIRED

### ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California  
County of \_\_\_\_\_)

On \_\_\_\_\_ before me, \_\_\_\_\_  
(insert name and title of the officer)

personally appeared \_\_\_\_\_,  
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature \_\_\_\_\_ (Seal)



## STATEMENT OF DISSOLUTION OF DOMESTIC PARTNERSHIP

I, \_\_\_\_\_, affirm under penalty of perjury, that:  
Name of Employee (print)

1. I, \_\_\_\_\_, and \_\_\_\_\_  
Name of Employee (print) Name of Domestic Partner (print)  
no longer reside together nor share the common necessities of life.
2. I affirm that the effective date of the dissolution of the domestic partnership is \_\_\_\_\_
3. I affirm that the effective date of the dissolution statement has been mailed to the other partner.
4. I understand that another Affidavit of Domestic Partnership cannot be filed until six (6) months from the date of filing this Statement of Dissolution.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Employee