



# HOUSE STAFF BENEFITS PLAN

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## HSBP ELIGIBILITY STATEMENT FOR DOMESTIC PARTNERSHIP

Participant's Name: \_\_\_\_\_  
(Last Name) (First Name)

Social Security No.: \_\_\_\_\_ Hospital where employed: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip code)

Contact phone number: \_\_\_\_\_ Type (home, mobile, etc.) \_\_\_\_\_

E-mail address: \_\_\_\_\_

1. I, \_\_\_\_\_, and  
(Name of Employee) (SS#)

I, \_\_\_\_\_, residing at  
(Name of Non-employee Domestic Partner) (SS#)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (Zip code)

certify that:

(Check one)

- \_\_\_\_\_ (A) we are registered as domestic partners in the City of New York, or
- \_\_\_\_\_ (B) (1) we are two unrelated individuals 18 years of age or older;  
(2) neither of us is married;  
(3) we have chosen to share one another's lives in a close and committed relationship of mutual caring;  
(4) we live together; and  
(5) have agreed to share responsibility for basic living expenses incurred during the domestic partnership.

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2. We submit documentation of two or more of the following:

(Check two or more)

- \_\_\_\_\_ (A) common ownership of real property or a common leasehold interest in such property;
  - \_\_\_\_\_ (B) common ownership of motor vehicle;
  - \_\_\_\_\_ (C) joint bank accounts or credit accounts;
  - \_\_\_\_\_ (D) Evidence of common household expenses such as a utilities or telephone;
  - \_\_\_\_\_ (E) Evidence of joint obligation on a loan;
  - \_\_\_\_\_ (F) designation as a beneficiary for life insurance or retirement benefits or under the partner's will;
  - \_\_\_\_\_ (G) assignment of a durable power of attorney or health care power of attorney;
  - \_\_\_\_\_ (H) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case; or
3. We understand that the information in number 2 is provided for the sole purpose of allowing HSBP to determine eligibility for domestic partnership benefits and that it is understood that the information provided will be held confidential.
4. We agree to notify the HSBP in writing if there is any change in the circumstance stated to obtain domestic partnership benefits;
5. We understand that unless the non-employee domestic partner or that domestic partner's child is a dependent of the insured employee for tax purposes under Section 152 of the Internal Revenue Code, the Internal Revenue Service currently treats as imputed income the value of the health coverage provided domestic partners and their dependents, if any, less any contribution paid by the employee coverage, therefore the value of these benefits will be added to the employee's income with possible withholding for payroll taxes on such amounts.
6. Each of certifies under penalty of perjury that the assertions in this declaration are true and correct to the best of our knowledge.

\_\_\_\_\_  
(Signature of Employee)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Non-employee Domestic Partner)

\_\_\_\_\_  
(Date)

Above signatures must be notarized.