HOUSE STAFF BENEFITS PLAN

10-27 46TH AVENUE, SUITE 300-2, LONG ISLAND CITY NY 11101

Phone: (212)-356-8180 **Fax: (212)-356 – 8181** benefits@cirseiu.org www.cirseiu.org

HSBP DOMESTIC PARTNERSHIP APPLICATION

Participant's Name: _____ _____
(Last Name) (First Name)

Social Security No.: _____Hospital where employed: _____

Home Address: _____ _____ _____ _____
(No. and Street) (City) (State) (Zip code)

Contact phone number: _____Type (home, mobile, etc.) _____

E-mail address: _____

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

I, _____ _____,
(Name of Non-employee Domestic Partner) (SS#)

residing at _____ _____ _____
(No. and Street) (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.

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

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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 us 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)

NOTARY SECTION

Please have a notary confirm the above signatures are correct with notary signature, date and seal below.

_____ _____ _____

(Signature of Notary) (Notary Stamp/Seal) (Date)

Hospitals That Cover Both Same Sex and Opposite Sex Domestic Partners:

Bellevue Hospital Center	Cambridge Health Alliance	Coney Island Hospital	Harbor UCLA Medical Center	Harlem Hospital Center	Jacobi Medical Center
Kings County Hospital Center	Lincoln Medical Center	Metropolitan Hospital Center	USC Medical Center	Westchester Medical Center	Woodhull Medical Center

FOR INTERNAL USE ONLY:

Notified hospital payroll? ☐ Yes ☐ No If yes, date: _____