CIR Benefit Funds

Domestic Partnership Application

Voluntary Hospitals House Staff Benefits Plan

MEMBER INFORMATION

First Name	Last Name	Social Security #
Address	**City**	**State**
Zip Code	**Phone Number**	**Email Address**

1. I, (Name of Employee) (Employee SS#), and I, (Name of Domestic Partner) (Domestic Partner SS#) certify that:

(Check one)

☐ A. We are registered as domestic partners

☐ 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 have lived together for at least 6 months; and
5. Have agreed to share responsibility for basic living expenses incurred during the domestic partnership.

2. We submit the following documentation:

☐ A. Domestic Partner Certificate or

Check two or more of the following:

☐ B. Common ownership of real property or a common leasehold interest in such property.
☐ C. Common ownership of a motor vehicle.
☐ D. Joint bank accounts or credit accounts.
☐ E. Evidence of common household expenses such as a utility or telephone.
☐ F. Evidence of joint obligation on a loan.
☐ G. Designation as a beneficiary for life insurance or retirement benefits or under the partner's will.
☐ H. Assignment of a durable power of attorney or health care power of attorney.

3. We understand that the information in section number two (2) is provided for the sole purpose of allowing VHHSBP 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 VHHSBP 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 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:

Brookdale Hospital Medical Center	Brooklyn Hospital Center	CarePoint Health Hoboken	Flushing Hospital Medical Center
Institute for Family Health - Harlem	Interfaith Medical Center	Jamaica Hospital Medical Center	Kingsbrook Jewish Medical Center
Maimonides Medical Center	Mt. Sinai Morningside/West	New York Methodist Hospital	St. John's Episcopal Hospital	Wyckoff Heights Medical Center

Hospitals That Cover Same Sex Domestic Partners:

BronxCare Health Center	CarePoint - Christ Hospital	Jersey City Medical Center	Montefiore Medical Center North

For Internal Use Only:

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