

# TULALIP TRIBES OF WASHINGTON



## Domestic Partnership

## Affidavit

### DOMESTIC PARTNERS

I, \_\_\_\_\_ certify that I, and \_\_\_\_\_  
( name of employee, please print ) ( name of domestic partner, please print )

Are Domestic Partners, and we:

1. Currently share the same regular and permanent residence, and
2. have a close and personal relationship, and
3. are jointly responsible for "basic living expenses," as defined below, and
4. are not married to anyone, and
5. are each eighteen (18) years of age or older, and
6. are not related by blood closer than would bar marriage in the State of Washington, and
7. were mentally competent to consent to contract when our domestic partnership began, and
8. are each other's sole domestic partner and are responsible for each other's common welfare.

"Basic living expenses" means the cost of basic food, shelter and any other expenses of a domestic partner. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

### EMPLOYEE

A. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change of circumstance attested to in this Affidavit as indicated above.

B. I agree to notify the Benefits Administrator for Tulalip if there is any change of circumstance attested to in this Affidavit , which would constitute a termination of the Domestic Partnership, within thirty (30) days of the change.

C. After such termination of this Domestic Partnership, I understand that another Affidavit of Domestic partnership cannot be filed within 90 days.

### AGREEMENT

A. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or if otherwise required by law and that this Affidavit is only applicable with respect to Tulalip's health plan.

B. We understand that this declaration of responsibility for our common welfare may have legal implications under Washington law.

C. We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, because of a false statement contained in this Affidavit of Domestic Partnership.

D. We also certify under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

E. I, the undersigned Employee, understand that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

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

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

\_\_\_\_\_  
Address

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

\_\_\_\_\_  
Employer/Department

Please note it is a crime to knowingly provide false, incomplete, or misleading information to a health plan for the purpose of defrauding the health plan. Penalties include imprisonment, fines, and denial of benefits.