Affidavit of Domestic Partnership

Employee’s Name _____________________ PID _____________________

Section 1 - This affidavit applies to the following University-sponsored Benefit Plans (please check all that apply):

☐ Group Term Life Insurance (MetLife)
☐ Accidental Death & Dismemberment Insurance (Reliance Standard)
☐ Dental Insurance (Assurant Dental)

This affidavit is to be completed by both the employee and the declared Domestic Partner. The affidavit must be notarized before submitting to the UNC General Administration Human Resources Office.

You should seek legal advice before signing this affidavit to ensure that you understand the possible legal effects of this acknowledgement of a Domestic Partner relationship.

Section 2 – Domestic Partnership Requirements

We certify that:

1.) we have an exclusive mutual commitment to share responsibility for each other’s welfare and financial obligations which has existed for at least 12 months prior to the enrollment in the plans listed in Section 1 and which commitment is expected to last indefinitely;

2.) we have lived together in the same residence for at least the last 12 months prior to the enrollment of the plans listed in Section 1;

3.) we are each 18 years of age or older;

4.) neither of us is married;

5.) we are not related by blood in a manner that would bar our marriage in the state of ________________, the state in which we reside; and

6.) neither of us has had another domestic partner within 12 months prior to the enrollment in the plan listed in Section 1.

We also certify that two or more of the following exist as evidence of joint responsibility for basic financial obligations (Please check those items that apply):

☐ joint mortgage or lease
☐ designation of Domestic Partner as durable power of attorney or health care proxy
☐ joint wills or designation of Domestic Partner as executor and/or primary beneficiary
☐ joint bank account, joint credit cards or other evidence of joint financial responsibility
☐ designation of the Domestic Partner as beneficiary for life insurance or retirement benefits
☐ other evidence that establishes economic interdependence (please specify in Section 4)

Please note: If enrolling for Group Term Life Insurance, at least one of the above must be either a joint mortgage or lease, or designation of the Domestic Partner as durable power of attorney or health care proxy.

Section 3 - Declaration of Domestic Partner
We declare that the statements in Section 2 are true and correct. We have read and understand the terms and conditions contained in this affidavit. We understand that any misrepresentation of fact can result in the loss of coverage and liability for incorrect benefit payments.

(1) Print Employee Name___________________________________________________

Employee Signature________________________________________  Date_________

(2) Print Domestic Partner Name____________________________________________

Domestic Partner Signature__________________________________  Date_________

(3) Address of Employee and Domestic Partner________________________________

______________________________________________________________________

(4) On what date did your Domestic Partnership begin____________________________

Section 4 – Additional Information (if necessary)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Section 5 – Notarization

State of _______________________________  County of_______________________________

On this day of ____________ in the year of_______________, before
me____________________________ personally appeared ________________________________

______________________________________________________________________________,

personally known to be (or proved to me on the basis of satisfactory evidence) the persons whose names are subscribed to this instrument and acknowledged that they executed it.

____________________________

Signature and Seal of Notary Public

Return the original notarized copy of this affidavit, along with the corresponding Benefit Enrollments Forms to the Benefit Program Administration Office.