AFFIDAVIT OF DOMESTIC PARTNERSHIP

If you are a registered domestic partner in California or another state you may provide proof of state registration in lieu of completing this Affidavit. If you reside in a state that you believe prohibits an employer from requiring you to complete the attached Affidavit, please contact the WGU Benefits at benefits@wgu.edu.

Section One (Employee & Domestic Partner)

I, _____ (Employee)

and

_____

are domestic partners and we:

(1) are each eighteen (18) years of age or older and are capable of consenting to the domestic partnership;
(2) are not related to each other by blood to a degree which is legally prohibited in marriage in the state in which we reside;
(3) are not married, in a civil union, or in a domestic partnership with any person other than the person with whom you execute this Affidavit;
(4) are in a committed spousal-type relationship of mutual interdependence in which each individual contributes to the other individual's maintenance and support as demonstrated by providing HR with one of the following supporting documents:
    a. A joint lease, mortgage or deed of primary residence;
    b. Joint ownership or lease of an automobile;
    c. Designation as the primary beneficiary of life insurance proceeds, retirement benefits, or the domestic partner's will.

Section Two (Employee)

1. I understand that my domestic partner is eligible for enrollment in the WGU group plans (e.g., medical, dental, vision, life, supplemental life) at the time of my hire or throughout the year based on the same eligibility criteria used for spouses.
2. I understand that this Affidavit shall be terminated upon the death of my domestic partner (after payment of any applicable life insurance proceeds, if applicable), or by a change in circumstance attested to in this Affidavit.
3. I agree to provide written notice to WGU Benefits if there is a change of circumstances attested to in this Affidavit within 60 days of the change by filing a Statement of Termination of Domestic Partnership. I understand that coverage will terminate retroactively if I give notice beyond the 60-day period.

Section Three (Employee & Domestic Partner)

1. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of a willful falsification of information contained in this Affidavit.
2. We understand that under applicable federal and state income tax law, payments for health coverage of a domestic partner may result in additional imputed taxable income to the employee, with possible

After your signatures have been notarized, please forward with supporting documents to WGU Benefits.

withholding for payroll taxes (including income and social security taxes) unless the employee's domestic partner qualifies as a dependent under Section 152 of the Internal Revenue Code.

3. We understand that, in addition to WGU's eligibility requirements for domestic partner coverage, there are terms and conditions of coverage set forth in the group life insurance policy and Group Agreement of each health care plan offered through WGU to which we agree to be bound. We acknowledge that:

   A. Depending on the health care plan we select, the applicable Group Agreement may include, for example and without limitation,

   (1) a requirement that each of us arbitrate any and all claims, including malpractice claims, against the health care plan we choose and its related organizations and providers; and

   (2) the right of the health care plan to terminate coverage on the grounds set forth in the Group Agreement
   including, without limitation, termination of coverage due to fraud, and misrepresentation of eligibility.

   B. The life insurance carrier cannot provide coverage for a domestic partner if the state in which we reside does not allow such coverage. We understand that it is our obligation to determine whether our state of residence allows such coverage.

4. By executing this Affidavit, we agree to be bound by the terms and conditions of coverage of the underlying coverages/plans selected as set forth in the applicable policies and/or Group Agreement, including the arbitration clause, if any.
5. We understand that willful falsification of information contained in this Affidavit may result in our termination of enrollment by the underlying plan that we select for coverage, a requirement that we repay the plan for claims paid, and possibly termination of the employee's employment.
6. We also certify under penalty of perjury under the laws of the State of _____, that the foregoing is true and accurate to the best of our knowledge.

_____ _____ _____ _____

Signature of Employee Date Signature of Domestic Partner Date

Address/City/State/Zip
Code_____

_____ _____ (attach additional page with Notary Seal)

Signature of Notary Date

After your signatures have been notarized, please forward with supporting documents to WGU Benefits.