Saratoga Hospital	
Title: Domestic Partner Designation	**Reference #:** 6.14
Origination Date: June 22, 2015	**Last Review/Revised Date:** January 18, 2021
Manual: Human Resources	**Replaces Policy:**
Document Owner: Ron Bentley, Sr. Human Resources Generalist	**Page:1 of 7**

Scope:

All benefit eligible employees.

Purpose Statement:

Saratoga Hospital extends benefits to those employees with a domestic partner. To be eligible, the domestic partner relationship must meet the criteria as outlined in this policy.

Definition:

A. Saratoga Hospital defines Domestic Partner as the same sex or opposite sex partner of a Saratoga Hospital employee who shares a committed relationship with the following characteristics:
   - Residing together for at least six (6) months;
   - Having a mutual and exclusive commitment to each other's wellbeing;
   - Being financially interdependent by sharing common assets and common debts for at least six months prior to the date domestic partnership recognition is being requested;
   - Neither party being married
   - Neither party having been in another domestic partnership within the last six (6) months
   - Not being related by blood closer than would bar marriage in the state of their residence; and
   - Both parties of legal age.

Policy or Procedure/Protocol Elements:

A. Benefit eligible employees in a domestic partner relationship are required to submit a Statement of Domestic Partnership (Attachment A) with the Human Resources department in order to access applicable benefits. Applicable benefits include: bereavement, courtesy discount, health, prescription, vision, dental coverage, and life insurance. For some benefit programs, additional criteria and documentation may be required by each insurance company. Approval of the attached Domestic Partner Affidavit does not mean your benefits have been approved.

B. Original documents must be presented with the registration form when notarized. Copies of original documents and the notarized registration form must be submitted to Human Resources. A copy of the form will be included as part of the employee's Human Resource file.

C. Employees are responsible for notifying Human Resources and completing the Statement of Change to Domestic Partnership Status (Attachment B) within thirty (30) days of any change in the domestic partner relationship (e.g. Marriage or termination of relationship status). To update your status to married, you will need to complete a marital status change request in Ultipro. To remove a domestic partner from any applicable benefit coverage and cancel the Domestic Partner designation you will need to complete the Ultipro Life Event titled **I want to remove a dependent**. Benefit coverage for the domestic partner (and his or her dependents where applicable) would be terminated the day in which the relationship ended. Employees are responsible for providing Human Resources with an appropriate mailing address of the former Domestic Partner to allow Human Resources to provide them required COBRA documentation. Confirmation of mailing address can be done by updating the contact information in their Ultipro record. A copy of the Statement of Change to Domestic Partnership Status will also be mailed to your domestic partner for their records.

D. Employees are responsible for completing the Annual Domestic Partnership Recertification form (Attachment C) that will be sent to all employees after the Open Enrollment Benefit's period to very relationship status. This document will serve as verification that no changes need to be made to the relationship status and/or benefit eligibility.

Domestic Partner Coverage Under Pre-Tax Benefit Plans

A. Benefit eligible employees can enroll domestic partners in benefit plans during the new hire period (within the first thirty (30) days from hire date), annual open enrollment or within (thirty (30) days of a qualifying event. The portion of the employee amount attributed to the domestic partner is not allowed to be deducted on a pre-tax basis. The amount is calculated and reported on the employee's paycheck as an earning for tax purposes and then as an offset deduction under the paycheck deductions. The Domestic Partner taxable portion of the benefit deductions are set annually as part of the open enrollment process.

Final Approval: Marcy A. Dreimiller, Vice President, Human Resources
Revision Dates: 1/18/21

Review Dates:
References:

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Attachment A: Affidavit of Domestic Partnership

The undersigned, begin duly sworn depose and declare as follows:

We are both eighteen years of age or older and unmarried. If either or both of us has been married, we submit evidence of the termination of the marriage.

We are not related by blood in a manner that would bar marriage under the laws of the State of New York.

We are each other's sole domestic partner, have been so for at least six months prior to the date of this affidavit, and intend to remain so indefinitely. We are in a relationship of mutual support, caring and commitment, and have assumed responsibility for each other's welfare.

We have been living together on a continuous basis for at least six (6) months prior to the date of this affidavit. One of us is enrolled in an employer group health insurance program.
Neither of us has been registered as a member of another domestic partnership within the last six (6) months.

I, the enrollee, affirm that I will file a Termination of Domestic Partnership form within thirty (30) days of the date I/my partner no longer meet one or more of the qualifying criteria set forth above.

I, the enrollee, understand that any false or misleading statement made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my partner and/or other legal actions appropriate to the prosecution of insurance fraud.

_____	_____
Print Name (Enrollee)	Print Name (Partner)
_____	_____
Address	Address
_____	_____
_____	_____
Date of Birth	Date of Birth
_____	_____
Signature	Signature

Sworn to before me this day of
NOTARY PUBLIC

HR Use Only:
Date Received: _____ By (Print Name) _____

Title: _____

Signature: _____

Attachment A: Proof of Six (6) Months Residency

To enroll your domestic partner in your employer health insurance benefits program, you must submit a copy of one item of proof that you and your partner have resided together for at least six (6) months. The proof may be one document with both names or two separate documents that show the residence of each partner. The following is a list of some items that can be used to demonstrate proof of residency. You may submit a copy of another document that proves residency began at least six months ago.

- ☐ Driver's License
- ☐ Auto Registration
- ☐ Lease Agreement
- ☐ Mortgage Agreement
- ☐ Tax Return
- ☐ Bank Statement
- ☐ Passport
- ☐ Insurance Benefits Statement
- ☐ Paycheck stub
- ☐ Utility Bill
- ☐ Telephone Bill
- ☐ Joint Membership (eg. Church or family association)
- ☐ Registration as a domestic partnership in the municipalities that have established such a procedure (e.g. New York City, Rochester, Ithaca)

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Attachment A: Affidavit of Financial Interdependence

The undersigned, being duly sworn, depose and declare as follows:

We are domestic partners who reside together and are financially interdependent. We submit original documents of two (2) of the following items (at least one (1) of the two (2) items must be from List A) as proof of our financial interdependence:
(Note: Original documents will be copied only to the extent necessary to document receipt and returned to you.)

List A

☐ Joint obligation on a loan (including an affidavit representative by creditor for a personal loan)
☐ Joint ownership of our residence
☐ Joint renters' or home owner's insurance policy
☐ Joint responsibility for childcare (e.g. school documents, guardianship)
☐ Designated as beneficiary under the other's life insurance policy, retirement benefits account, will, or executor of each other's wills
☐ An affidavit by a creditor or other person able to testify to partner's financial interdependence
☐ Mutually granted durable power of attorney

List A (continued)

☐ Designation of one partner as the payee for the other's government benefits
☐ Joint ownership or holding of investments
☐ Joint ownership or lease of a motor vehicle
☐ Both listed as tenants on the lease of our shared residence
☐ Mutually granted authority to make health care decisions (e.g. health care power of attorney)
☐ Share a household budget for the purpose of receiving government benefits
☐ I claim my partner as a dependent for federal tax purposes

List B

☐ Joint bank account
☐ Joint credit or charge card(s)

List B (continued)

☐ Status as authorized signatory on the partner's bank account, credit cards, or charge card
☐ Other proof establishing economic interdependence

NOTE: Proof submitted must show financial interdependence for at least six (6) months.

_____	_____
Print Name (Enrollee)	Print Name (Partner)
_____	_____
Address	Address
_____	_____
_____	_____
Date of Birth	Date of Birth
_____	_____
Social Security Number	Social Security Number
_____	_____
Signature	Signature

Sworn to before me this day of
NOTARY PUBLIC

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Attachment B: Statement of Change to Domestic Partnership Status

Please Print:

I, _____, certify and declare that:
(Employee's Name)

☐ **Termination of Domestic Partnership:**

1. As of _____, _____ and I are no longer
(mo/day/yr) (domestic partner's name)
domestic partners.
2. I make and file this Statement of Termination of Domestic Partnership with Saratoga Hospital on _____.
(mo/day/yr)

I understand that:

a. Health/RX, Dental, and Vision coverage for my domestic partner and his/her dependents (if applicable) as well as the Courtesy Discount will end on the date in which the domestic partnership ended.
b. I will be responsible for paying all premiums for benefits for all pay periods in which my domestic partner and his/her dependents (if applicable) had coverage.
c. A copy of this document will be sent by Saratoga Hospital Human Resources to my former domestic partner at his/her address listed below along with any COBRA documentation (if applicable):

_____
(# and street address) (City) (State/Zip Code)

☐ **Marriage:**

1. As of _____, _____ and I are married.
(mo/day/yr) (domestic partner's name)

I understand that:

a. I must provide Human Resources with a copy of my marriage license.
b. I must complete a marital status change request in Ultipro to change my marital status from single to married
c. **If changing my name**, I must provide Human Resources with a copy of my new social security card and professional license (if applicable).
d. **If changing my name**, I must complete a name change request in Ultipro.

I certify that the above information is correct.

_____ _____
(Employee's Signature) (Date)

HR Use Only:
Date Received: _____ By (Print Name) _____

Title: _____

Signature: _____

Attachment C: Annual Recertification of Domestic Partnership

Please Print:

_____ _____
(Employee's Name) (Domestic Partner's Name)

We certify that:

- We are still each other's sole domestic partners
- Neither of us are legally married to anyone
- We have been living together on a continuous basis for the last year (or as of date of previous domestic partnership affidavit completion)

We understand that:

- We must notify Human Resources if there is any changes in our status as domestic partners including marriage or termination of domestic partnership. We will notify Human Resources within thirty (30) days of such change by filing a Statement of Change to Domestic Partnership Status.
- Any false or misleading statements made in order to receive benefits for which we do not qualify for will subject me to financial responsibility for any benefits paid on behalf of my partner and/or other legal actions appropriate to the prosecution of insurance fraud.

We certify that the above information is correct.

_____ _____
(Employee's Signature) (Date)

_____ _____
(Domestic Partner's Signature) (Date)

HR Use Only:
Date Received: _____ By (Print Name) _____

Title: _____

Signature: _____

Document Information

Document Title

Domestic Partnership Policy 6.14

Document Description

N/A

Approval Information

Approved On: 01/18/2021

Approved By: Ronald Bentley (Human Resources: rbentley) on 01/18/2021

Approval Expires: 11/22/2022

Note: .