



State of New York
 Department of Civil Service
 The State Campus
 Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

Application for Employee Benefits for Domestic Partners of Active New
 York State Employees and Affidavit of Domestic Partnership and
 Financial Interdependence

PS-425.1 (9/01L)

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

1. 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(s).
2. We are not related by blood in a manner that would bar marriage under the laws of the State of New York.
3. We are each other's sole domestic partner, have been so for at least one year 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.
4. We have been living together on a continuous basis for at least one year prior to the date of this affidavit and submit proof of qualifying cohabitation (see reverse side for proof of residency).
5. As domestic partners we are financially interdependent. We submit original documents of two proofs of our financial interdependence (see reverse side for proofs of financial interdependence).
6. One of us is enrolled in the New York State Health Insurance Program (NYSHIP).
7. Neither of us has been enrolled in NYSHIP as a member of another domestic partnership within the last two years.
8. I, the enrollee, affirm that I will file a *Termination of Domestic Partnership* form (PS-425.4) within 14 days of the date I/my partner no longer meet one or more of the qualifying criteria set forth above.
9. I, the enrollee, understand that any false or misleading statements 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 potential disciplinary action by my employer.

Print Name (Enrollee)
Social Security No.
Address
Signature (sign in presence of notary)

Print Name (Partner)
Social Security No.
Date of Birth
Address
Signature (sign in presence of notary)

Sworn to before me _____ this day of _____, _____

 NOTARY PUBLIC

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of determining the eligibility of a domestic partner for benefits under the New York State Health Insurance Program, Dental Program, Vision Program, and/or Employee Benefit Fund Program. The information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (c) and (f). Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Dept. of Civil Service, The State Campus, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375. For information related to the Domestic Partnership Program, contact your Agency Health Benefits Administrator. If, after calling your Health Benefits Administrator, you still have questions, call (518) 457-6754 or 1-800-933-1344.

**YOU NEED A TOTAL OF 3 SEPARATE PROOFS*, AS DESCRIBED BELOW
(1 PROOF OF COHABITATION DURATION AND
2 PROOFS OF FINANCIAL INTERDEPENDENCE)**

*Proofs should be clearly unaltered copies of original documents.

Proof of One Year Cohabitation

You must submit proof that you and your partner have resided together for at least one year. 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 items that can be used to demonstrate proof of residency.

Submit one (1) of the following (check proof submitted):

- | | |
|--|---|
| <input type="checkbox"/> Auto registration | <input type="checkbox"/> Passport |
| <input type="checkbox"/> Bank statement | <input type="checkbox"/> Pay check stub |
| <input type="checkbox"/> Driver's license | <input type="checkbox"/> Registration as a domestic partnership in a New York State municipality that has established such a procedure (e.g., Albany, New York City, Rochester, Ithaca) |
| <input type="checkbox"/> Mailed insurance benefits statement | <input type="checkbox"/> Tax return |
| <input type="checkbox"/> Mailed joint membership statement with address (e.g., church or family association) | <input type="checkbox"/> Telephone bill |
| <input type="checkbox"/> Lease agreement listing both parties | <input type="checkbox"/> Utility bill |
| <input type="checkbox"/> Mortgage agreement listing both parties | |

Proof of Financial Interdependence

You must submit two (2) copies of clearly unaltered original documents as proof of financial interdependence of at least one year duration. Below is a list of acceptable proofs (at least one of the two items must be from List A). Check the two (2) proofs you are submitting:

Note: "Joint" proofs must contain both names (enrollee and domestic partner). Original documents will be copied only to the extent necessary to document receipt and returned to you.

LIST A

- | | |
|--|---|
| <input type="checkbox"/> Joint obligation on a loan (including an affidavit by a creditor for a personal loan) | <input type="checkbox"/> Designation of one partner as the representative payee for the other's government benefits |
| <input type="checkbox"/> Joint ownership of your residence | <input type="checkbox"/> Joint ownership or holding of investments |
| <input type="checkbox"/> Joint renters' or home owners' insurance policy | <input type="checkbox"/> Joint ownership or lease of a motor vehicle |
| <input type="checkbox"/> Joint responsibility for child care (e.g., school documents, guardianship) Birth certificate of child alone is not sufficient. | <input type="checkbox"/> Both listed as tenants on the lease of shared residence |
| <input type="checkbox"/> Designated as beneficiary under the other's life insurance policy, retirement benefits account or will or executor of each other's will | <input type="checkbox"/> Mutually granted authority to make health care decisions (e.g., health care power of attorney) |
| <input type="checkbox"/> An affidavit by a corporate creditor or other disinterested third-party qualified to testify to partners' financial interdependence | <input type="checkbox"/> Share a household budget for the purpose of receiving government benefits |
| <input type="checkbox"/> Mutually granted durable power of attorney | <input type="checkbox"/> I claim my partner as a dependent for federal tax Purposes (you must complete and submit PS-425.3) |

LIST B

- | | |
|---|---|
| <input type="checkbox"/> Joint bank account | <input type="checkbox"/> Status as authorized signatory on the partner's bank account, credit card or charge card |
| <input type="checkbox"/> Joint credit or charge card(s) | <input type="checkbox"/> Other proof establishing economic interdependence |