



Declaration of Spouse or Domestic Partnership for Benefit Eligibility

SECTION 1 – Relationship Declaration

Employee Name (print): _____

Employee Signature: _____ Date: _____

Spouse or Domestic Partner Name (print): _____

Spouse or Domestic Partner Signature: _____ Date: _____

We certify that the individuals listed above meet the criteria indicated below (check one):

Legally Married on (date): _____
(Skip to Section 3)

Domestic Partnership as defined below:

For the purpose of this declaration, a domestic partnership is defined as two individuals who:

1. Jointly share the same permanent residence and intend to do so indefinitely;
2. Are committed to each other to the same extent as married persons, but are not legally married;
3. Are not legally married to anyone else;
4. Are each at least 18 years old or emancipated minors under Oregon law;
5. Are not related by blood in a way that would bar marriage in Oregon;
6. Were mentally competent to consent to a contract at the start of the partnership and remain so;
7. Are each other's sole domestic partner and have been for at least six months;
8. Are jointly responsible for each other's common welfare and necessities of life.

Note: "Necessities of life" may include costs such as food, rent, mortgage, utilities, and insurance, regardless of whether expenses are shared equally. Joint responsibility must be demonstrated.

SECTION 2 – Acknowledgments

(Employee and domestic partner must initial each item)

1. ____/____ We are subject to the provisions of the health plan and any domestic partnership endorsement.
2. ____/____ We understand that unless tax-qualified status is certified, the fair market value of

coverage for the domestic partner and/or their children will be added to the employee's taxable income.

3. ____/____ We understand that we must submit a Health & Dental Enrollment form and any required documentation to add a domestic partner and/or their children.

SECTION 3 – Certification and Legal Notice

By signing below, I acknowledge:

- The information provided in this declaration will be used solely to determine benefits eligibility and will not be shared except as authorized by law or with my written consent.
- Signing this form may have legal implications beyond insurance coverage. The City of Springfield is not liable for any resulting legal effects. I am encouraged to consult with legal counsel.
- I must provide proof of marriage or domestic partnership if requested by the City. Failure to do so within 30 days may result in retroactive termination of coverage and reimbursement of any costs incurred by the City.
- Submitting false or misleading information may result in disciplinary action, including termination.
- This declaration terminates upon the death of my spouse or partner or a change in any of the circumstances listed above. I must notify HR within 30 days of such change by submitting a Termination of Domestic Partnership, Health Insurance Benefits or Tax Status form.
- A new partner cannot be declared until six months have passed following submission of a termination form.
- Failure to notify HR may result in a paycheck deduction and/or further disciplinary action, including termination.

The City will keep this declaration confidential to the extent permitted by law.

Employee Name (print): _____

Employee Signature: _____ **Date:** _____

Spouse or Domestic Partner Name (print): _____

Spouse or Domestic Partner Signature: _____ **Date:** _____