



Northwestern University

Declaration of Same-Gender Domestic Partner Relationship

Submit completed form to
Benefits Division
720 University Place
Evanston, IL 60208

EMPLOYEE PERSONAL INFORMATION

EMPLOYEE NAME (Last Name, First Name MI)			EMPLOYEE ID _____
DATE OF BIRTH ___/___/___	DATE OF HIRE ___/___/___	E-MAIL ADDRESS	CAMPUS TELEPHONE NUMBER
HOME ADDRESS			

DOMESTIC PARTNER INFORMATION

DOMESTIC PARTNER NAME (Last Name, First Name MI)	SOCIAL SECURITY NUMBER ____-____-____	DATE OF BIRTH ___/___/___
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CERTIFICATION

I, _____, and _____ certify that we live in a committed relationship and are each other's Domestic Partner in accordance with the following criteria and are eligible for University benefits as Domestic Partners. We:

- are each other's sole Domestic Partner and intend to remain so indefinitely
- are of the same gender
- are not legally married to anyone
- are both age 18 or older and mentally competent to consent
- are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which we legally reside
- would marry or establish a legally recognized Domestic Partnership if it were available to us under the laws of the state in which we live
- are jointly responsible for each other's common welfare and share financial obligations which could be demonstrated upon request by providing proof of the existence of at least **three** of the following (please check):
 - joint mortgage or lease or other appropriate written evidence of common residence such as joint utility bills
 - designation of Domestic Partner as primary beneficiary in either:
 - my or my Domestic Partner's will, or
 - Life Insurance, or
 - Retirement Plan
 - durable property or health care power of attorney
 - joint ownership of motor vehicle
 - joint checking account or joint credit account

SIGNATURE OF EMPLOYEE	DATE:	SIGNATURE OF DOMESTIC PARTNER	DATE:
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CHANGE IN DOMESTIC PARTNERSHIP

I agree to inform the University if my eligibility requirements change causing my Domestic Partner to become ineligible. I must inform the University within 31 days of my eligibility change.

I understand that if I elect to cover my Domestic Partner under any of the University's health, dental, vision, or life insurance plans and if the relationship ceases my Domestic Partner and other covered dependent children are eligible for coverage under COBRA.

I understand if my Domestic Partner relationship terminates that a subsequent Declaration of Same-Gender Domestic Partnership cannot be filed until 6 months after a Statement of Termination of the previous partnership has been received by the University.

ACKNOWLEDGEMENT

I understand that I have the opportunity to cover my Domestic Partner under University benefits plans under the same terms and with the same privileges and restrictions that apply to spouses and eligible dependent children. I understand that this declaration does not act as an enrollment form. **A Benefits Change form, or online enrollment in HRIS Self Service for new hires, is still required to enroll my partner in any University benefits.**

I understand that benefits I elect for my Domestic Partner using this Declaration will remain in effect as long as I meet the eligibility requirements.

I understand that Northwestern University is required by the Internal Revenue Service (IRS) to report as taxable income the premium value related to covering my Domestic Partner under the employee health, dental or vision benefit plans.

SIGNATURE OF EMPLOYEE	DATE
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Office Use Only	<input type="checkbox"/> Entered in HRIS <input type="checkbox"/> Submitted to Payroll	Effective Date:
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