

ASSOCIATED GENERAL CONTRACTORS OF AMERICA,
SAN DIEGO CHAPTER, INC.
HEALTH AND WELFARE TRUST FUND

DOMESTIC PARTNER DECLARATION

I, _____, SS# _____, submit this
(Name of Employee)

Domestic Partner Declaration for the purpose of covering my domestic partner as my dependent under the Associated General Contractors of America, San Diego Chapter, Inc. Health and Welfare Trust Fund ("Trust Fund"). I recognize that the Trust Fund defines "domestic partners" as two adults who have chosen to share their lives in a committed relationship, reside together, and share a mutual obligation of support for the bare necessities of life.

In order to establish eligibility for domestic partner coverage, I understand that the Trust Fund will need the following information. I declare and acknowledge that the following facts are true and correct:

INFORMATION

Domestic Partner's Name _____ SS# _____

Date domestic partnership was established _____

Please answer all of the following questions:

1. Do you share the same residence? _____ If so, what date did shared residency begin? _____ If so, what is the address of the residence? _____
2. Are you each other's sole domestic partner and intend to be so indefinitely? _____
3. Are either of you married? _____
4. What is your domestic partner's age? _____
5. Are you blood relatives, parents, or siblings of one another? _____

REQUIREMENTS

We understand that if the domestic partnership is approved for coverage under the Trust Fund, we must continually meet the following requirements:

- we have lived together for twelve (12) consecutive months
- we are jointly financially responsible for "basic living expenses"
- we are mentally competent to consent to this arrangement
- we are each other's sole domestic partner indefinitely
- we are not married under applicable state law and have not had other domestic partners within the past twelve (12) months
- we are at least 18 years of age
- we are jointly responsible for each other's welfare
- we are not blood relatives
- we understand that a statement of good health for the domestic partner must be submitted and approved
- we understand that domestic partner contributions for medical and other coverage will be considered post-tax
- we understand that employer contributions for the domestic partner coverage will be considered imputed income (taxable) to the employee

SWORN ACKNOWLEDGMENT

I acknowledge that:

- I cannot file another Declaration of Domestic Partnership Declaration for a new Domestic Partnership until at least twelve (12) months after a Statement of Termination of Domestic Partnership has been filed.
- If requested, I will provide to the Plan Administrator or designated representative documents establishing the existence of my Domestic Partnership relationship.
- I understand that I would be well-advised to consult an attorney regarding the possibility that the filing of this Declaration may have certain legal consequences, including the fact that it may, in the event of the termination of the Domestic Partnership relationship, be

regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purpose of establishing and dividing community property, or for ordering payment of support.

- I have an obligation to file a Statement of Disenrollment, Legal Separation, Death, or Termination of Domestic Partnership with the Plan Administrator or designated representative within thirty (30) days of the earliest of (a) the death of my Domestic Partner; (b) the date of legal separation; (c) the date of the divorce decree; or (d) the date on which any of the criteria of a Domestic Partnership relationship is no longer met.
- I further understand that the effective date of the end of the Domestic Partnership relationship is the earliest of (a) the death of my Domestic Partner; (b) the date of legal separation; (c) the date on which I file a Statement of Disenrollment, Legal Separation, Death or Termination of Domestic Partnership with the Plan Administrator or designated representative.
- I understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statement contained in this Domestic Partnership Declaration, including claims paid under any benefit plans in which I enroll my Domestic Partnership.

I declare, under penalty of perjury, that the statements in this Declaration are true to the best of my knowledge.

Dated: _____

(Signature)

(Name of Employee)

(Address)

(City, State, ZIP Code)

