

**SCREEN ACTORS GUILD-PRODUCERS HEALTH PLANS
AFFIDAVIT OF DOMESTIC PARTNERSHIP**

_____ **AND** _____
(Participant's name) (Domestic Partner's name)

1. We are the sole domestic partner of each other and have no other domestic partners.
2. We are the same sex and neither of us is married.
3. We have resided together for the immediately preceding 6 months and intend to do so indefinitely.
4. We have been domestic partners as evidenced by documentation listed in item #6 of this affidavit since

_____.
(month) (day) (year)

5. We have not had a spouse or another domestic partner in the last 6 months.
6. We have undertaken a relationship of mutual financial support, which shall continue as long as we are domestic partners. This relationship imposes upon us the same financial commitments (including, in some cases, liability for each other's debts) that would exist if we were married as husband and wife in the state and county in which we reside. In proof of this relationship of mutual financial support, we agree that **OUR ACT OF SIGNING THIS DOCUMENT CERTIFIES THE SAME RELATIONSHIP OF MUTUAL FINANCIAL SUPPORT BETWEEN US AS IF WE MARRIED AS HUSBAND AND WIFE IN THE STATE AND COUNTY IN WHICH WE RESIDE.** The relationship created by our signature to this document shall supersede the terms of any previous financial arrangements between us, to the extent they are inconsistent with the relationship described above.

We will provide the Screen Actors Guild - Producers Health Plan (Health Plan) with evidence of **at least three** of the items listed below (check the applicable items):

NOTE: Documentation submitted must be in excess of 6 months old

- Domestic Partnership Declaration issued by appropriate government agency
- Joint mortgage or lease

- Designation of domestic partners as each other's life insurance or pension beneficiary
- Designation of domestic partners as each other's primary beneficiary in will or as each other's successor trustee or co-trustee in a living trust
- Joint ownership of vehicle or primary checking account or primary joint credit account
- Other documentation satisfactory to the Health Plan confirming mutual support

We further agree to submit immediately to the Health Plan any modifications to the arrangements described above, and understand that the extension of coverage to the domestic partner of the Participant will cease if such modification causes the relationship of mutual financial support to be altered.

7. We are aware that we are subject to the eligibility rules governing all other Participants and dependents covered by the Health Plan subject to certain limitations relating to domestic partners.
8. We are aware that it is the Health Plan's interpretation of current tax law that by enrolling for domestic partner coverage, we are incurring various tax liabilities unless the domestic partner is a "dependent" as defined in the Internal Revenue Code. We agree to prepay to the Health Plan the taxes the Health Plan determines are due. All taxes are calculated based on the Internal Revenue and state rate tables for a single person with zero withholding allowances. We further acknowledge that such prepayments are computed to include the employer's portion of such taxes, which, if overpaid, we may not be able to completely recover. Taxes are computed at the beginning of the calendar quarter based on the address shown on the Participant's Performer Information Form as of the date payment is made. No adjustments will be made to the quarterly payment due to changes in our address and/or eligibility type until the following quarter. If coverage begins during the second or third month of a calendar quarter, the initial tax payment will be prorated.

In any case, we shall indemnify and hold the Health Plan harmless for any taxes, tax-related penalties, or interest imposed upon the Health Plan as a result of providing domestic partner coverage to us.

9. We acknowledge that if we are prepaying taxes, the Health Plan is collecting taxes as a convenience to us and it is submitting the taxes on our behalf to the appropriate taxing authorities; but we agree that the Health Plan is not our employer for any purpose including claims for unemployment insurance.
10. We shall provide the Health Plan notice within 10 days if there is any change in our domestic partner status.
11. We are at least 19 years old and of sufficient mental capacity to enter into this contract. We will provide the Health Plan with certified copies of our birth certificates.
12. We are not related by blood to a degree that would prohibit marriage in the state of our residence.
13. Each of us is jointly and individually responsible for reimbursement of benefits or expenses, including, attorney's fees, interest, liquidated damages, court costs and other costs of collection incurred by the Health Plan as the result of any false or misleading statement contained in this affidavit or in connection with any litigation to collect amounts outstanding.
14. The address on the next page is our residence for tax purposes. We agree to notify the Health Plan within 10 days of any changes in our residence.

Is your domestic partner Medicare eligible? Yes No

Is your domestic partner a member of SAG? Yes No

Does your domestic partner have other health insurance? Yes No

Participant's Date of Birth:

_____/_____/_____
 Month Day Year

Domestic Partner's Date of Birth:

_____/_____/_____
 Month Day Year

Each of us affirms, under penalty of perjury of the laws of the State of _____ that the statements in this affidavit are true to the best of our knowledge.

Domestic Partner's signature

Participant's signature

Print Domestic Partner's name

Print Participant's name

Domestic Partner's SS#

Participant's SS#

Common Address: _____

Common Telephone: (____) _____

NOTARIZATION

STATE OF _____]
COUNTY OF _____] ss.

On _____, before me, _____
(Date) (Name, title of officer - e.g. Jane Doe, Notary Public)
personally appeared _____, and
(Participant)

(Domestic Partner)

Who proved to me on the basis of satisfactory evidence to be the people whose names are subscribed to the within instrument and acknowledged to me that they executed the same in their authorized capacities.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing is true and correct.

WITNESS my hand and official seal.

Signature of Notary _____