

INSTRUCTIONS: Please complete and sign this Affidavit before a Notary Public and submit it to GHI or GHI HMO, as applicable, only if your domestic partnership resides in a jurisdiction or municipality that does not have a domestic partner registry. If your domestic partnership resides in a jurisdiction or municipality that has such a registry, you must register your domestic partnership with the jurisdiction or municipality and submit proof of such registration to GHI or GHI HMO, as applicable, along with the completed Declaration of Cohabitation and Financial Interdependence Form.

Domestic partner benefits may have federal and state tax consequences. You should consult the applicable laws and/or a tax professional before applying to enroll your domestic partner for dependent health coverage.

ALTERNATIVE AFFIDAVIT OF DOMESTIC PARTNERSHIP

The undersigned, being duly sworn, depose and declare that all of the following statements are true:

- We are both eighteen (18) years of age or older and unmarried.
- We are not related by blood in a manner that would bar marriage under the laws of the State of New York.
- We have a close and committed personal relationship.
- We have been living together on a continuous basis for at least six (6) months prior to the date of this affidavit.
- Neither of us has been registered as a member of another domestic partnership within the last (6) months.
- We are submitting this Affidavit and the Declaration of Cohabitation & Financial Interdependence Form so that GHI and GHI HMO may determine whether the partner named below is eligible for dependent health benefits coverage. We understand that our submission of these forms does not automatically enroll us in the GHI or GHI HMO health benefits program.
- We understand that, in the event we no longer meet the criteria attested to in this Affidavit and the Declaration of Cohabitation & Financial Interdependence Form, we will no longer be a domestic partnership as defined by GHI and GHI HMO and the partner named below will no longer be eligible for GHI or GHI HMO dependent coverage.

Print Name of Employee/GHI Subscriber

Print Name of Partner

Signature

Signature

STATE OF _____)

: SS.:

COUNTY OF _____)

Sworn to before me this _____ day of _____, 20____.

Notary Public