



# HARRISON TRUST

*A Family Health Plan*

**www.harrison.aibpa.com**

## AFFIDAVIT OF DOMESTIC PARTNERSHIP FOR EMPLOYEE

State of \_\_\_\_\_

County of \_\_\_\_\_

I, \_\_\_\_\_ (Name of Employee), being first duly sworn,  
do hereby say as follows:

1. I and \_\_\_\_\_ (Name of Domestic Partner) are domestic partners and meet all the following requirements:
  - a. We are residing together at the same permanent address and sharing the common necessities of life.
  - b. I am not married or registered as the domestic partner with any other person in any jurisdiction.
  - c. I have not been married or had another domestic partner at any time during the previous six months; or, if I have been married or had another domestic partner in the previous six months, that individual is deceased.
  - d. I am at least age 18.
  - e. My domestic partner is not related to me by blood kinship closer than would bar marriage in the state in which I reside.
  - f. I am mentally competent to consent to contract when the domestic partnership began and remain mentally competent.
  - g. \_\_\_\_\_ (Name of Domestic Partner) is my sole domestic partner; we have a close personal relationship; we intend to remain domestic partners indefinitely; and we are responsible for each other's common welfare, including but not limited to food, shelter and other necessary living expenses.
  
2. My domestic partnership with \_\_\_\_\_ (Name of Domestic Partner) started on or about \_\_\_\_\_ (Insert Month, Date and Year) and still exists.

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3. I agree to notify the Trust Office in writing as soon as all the conditions in paragraph 1 above are no longer applicable or my domestic partner dies. The address of the Trust Office is:

Harrison Electrical Workers Trust Fund  
c/o A&I Benefit Plan Administrators, Inc.  
1220 SW Morrison Street, Suite 300  
Portland, OR 97205

4. I understand and agree that if I have made any false statements in this affidavit, and the Harrison Trust suffers any loss as a result thereof, the Harrison Trust or Board of Trustees may bring a civil action against me to recover any losses incurred by the Harrison Trust, including reasonable attorney's fees and court costs.
5. I understand and agree that if any of the representations or statements in this affidavit are no longer true and correct, for example, all the statements in paragraph 1 are no longer true, I must notify the Trust Office in writing in accordance with paragraph 3 within 30 days. If I fail to notify the Trust Office in writing in accordance with paragraph 3, and the Harrison Trust suffers any loss as a result thereof, the Harrison Trust or the Board of Trustees may bring a civil action against me to recover any losses incurred by the Harrison Trust, including reasonable attorney's fees and court costs.
6. Signing this affidavit may have legal implications affecting relations between domestic partners beyond the extension of health and welfare coverage. If you desire further information concerning possible legal consequences of signing this affidavit, consult an attorney of your choice. If you desire further information concerning possible tax consequences of signing this affidavit, consult a tax advisor of your choice.
7. I certify under penalties of perjury that the information in this affidavit is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
(Signature of Employee)

Date: \_\_\_\_\_

\_\_\_\_\_  
Notary Public for the State of \_\_\_\_\_