THE NEW YORK HOTEL TRADES COUNCIL
HEALTH BENEFITS FUND
THE HOTEL ASSOCIATION OF NEW YORK CITY, INC.

305 West 44th Street • New York, NY 10036 • (212) 586-6400 • Fax: (212) 459-1699 • **HotelFunds.org**

Domestic Partnership Package

Please read this entire packet prior to completing it. At the end of this packet you and your qualified domestic partner will be required to sign a sworn **Domestic Partnership Affidavit** (see page 5) acknowledging that you have received, read, and accept the rules, requirements and obligations outlined in this Domestic Partnership Affidavit. A copy of this document should be kept in a safe place for your records.

DOMESTIC PARTNERSHIP RULES

- Upon first certifying as domestic partners, your qualified domestic partner and his or her dependent children will be eligible for health benefits no earlier than ninety (90) days following the date this document is completed and presented to the Fund office.

- For continued coverage, you and your qualified domestic partner must recertify and file a new **Domestic Partnership Affidavit** with all required documentation every twelve months. As long as you recertify by this annual deadline, there will be no additional waiting period for renewed eligibility.
    - If you do not recertify by your annual deadline, your domestic partner and his or her dependent children will lose health coverage until you again certify your domestic partnership status.

- You can have only **one** qualified domestic partner *or* one spouse active on your health plan at a time.

- Health benefit coverage for qualified domestic partner and their dependents will respectively match those provided to spouses and dependents as stated in the Health Benefits Fund Summary Plan Description, available at **HotelFunds.org** or through our Fund office. Qualified domestic partners and their dependents are also subject to the same Plan rules stated in this Summary Plan Description.
    - Other benefits, such as Pre-Paid Legal, Industry Training Program and Scholarship are not available to domestic partners or children of domestic partners.

- Domestic partners are not considered "qualified beneficiaries" under the federal COBRA laws and therefore will have no right under the law for continued self-pay benefits after a "qualifying event" which causes loss of health coverage.

- The covered member must notify the Fund Office within fifteen (15) days of any change in status as domestic partners which would change eligibility for Fund benefits. Upon termination of domestic partner status, the covered member must also submit a **Statement of Domestic Partnership Termination** (included on last page) to the Fund Office and mail a copy to the domestic partner within the same fifteen (15) day timeframe.

- Qualified domestic partners must prove that they have resided together and been <u>financially interdependent for at least six months</u> prior to the submission of this affidavit. Any dependent children being enrolled for coverage have also met this residency and financial interdependence requirement.

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DOMESTIC PARTNER ENROLLMENT FORM

To enroll a qualified domestic partner and his or her eligible dependents for benefit coverage, the covered member and domestic partner must appear personally at the Health Benefits Fund office. The **Domestic Partnership Affidavit** and all required documents must be received and approved by the Fund office before enrollment can be accepted. Each dependent's original birth certificate must be presented to the Fund office. Dependents must reside at the same address as the covered member and qualified domestic partner.

COVERED MEMBER INFORMATION:

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER

ADDRESS	CITY	ST	ZIP CODE

DOMESTIC PARTNER INFORMATION:

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER
DATE OF BIRTH	GENDER ☐ Male ☐ Female		☐ Currently Enrolled

ADDRESS	CITY	ST	ZIP CODE

COORDINATION OF BENEFITS: DOMESTIC PARTNER'S WORKPLACE & HEALTH INSURER

A copy of the health insurer's identification card must be supplied, if applicable.

WORKPLACE WHERE ABOVE DOMESTIC PARTNER IS/WAS EMPLOYED	WORKPLACE TELEPHONE NUMBER

ADDRESS OF ABOVE WORKPLACE	CITY	ST	ZIP CODE

HEALTH INSURER OF ABOVE DOMESTIC PARTNER	HEALTH INSURER TELEPHONE NUMBER

ADDRESS OF ABOVE HEALTH INSURER	CITY	ST	ZIP CODE

DEPENDENT CHILD OF DOMESTIC PARTNER ENROLLMENT:

Documentation Accepted for Each Dependent ☐

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER
DATE OF BIRTH	GENDER ☐ Male ☐ Female		☐ Currently Enrolled
FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER
DATE OF BIRTH	GENDER ☐ Male ☐ Female		☐ Currently Enrolled
FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER
DATE OF BIRTH	GENDER ☐ Male ☐ Female		☐ Currently Enrolled

By signing below, I confirm that I wish to enroll the above-named qualified domestic partner and, if applicable, his or her dependent(s) to my health insurance policy with the New York Hotel Trades Council & Hotel Association of New York City, Inc. Health Benefits Fund (Health Center, Inc.). I certify that all information supplied on this form is accurate and complete. I understand that I am obligated to immediately notify the Health Benefits Fund of any change of information that affects the health coverage eligibility of any person covered under my health plan. I understand that any person who knowingly files any claim or application for coverage and/or for health benefits which contains false information or conceals information may have his or her health coverage revoked and may be subject to legal action to recover the amount of related losses.

Covered Member's Signature **Date** (mm/dd/yyyy)

Printed Name & Signature of Benefits Fund Staff Who Has Approved this Enrollment:

COVERED MEMBER OBLIGATION TO NOTIFY THE FUNDS WITH RESPECT TO CHANGE IN DOMESTIC PARTNER STATUS

1. I agree to notify the Fund office if there is any change in our status as domestic partners which would change our eligibility for Fund benefits (for example, if we cease to reside together or if we are no longer each other's sole domestic partner).

   I will notify the Fund office within fifteen (15) days of such change by filing a Statement of Domestic Partnership Termination (see last page of this affidavit), affirming that the domestic partner status has ended and that a copy of this statement has been mailed to the domestic partner by the Covered Member.

   I understand that if I do not inform the Fund office on a timely basis of any change in our status as domestic partners, the Fund will have the right to recover from myself or my domestic partner for any damages incurred for reimbursement of the costs for health services provided.

2. After such termination, I understand that a subsequent Affidavit of Domestic Partnership cannot be filed until six (6) months after a Statement of Domestic Partnership Termination has been filed with the Fund. The six-month waiting period will be waived only if another affidavit is filed for the same domestic partner, who is a signatory to this Affidavit.

_____

Covered Member's Signature **Date** (mm/dd/yyyy)

ADDITIONAL ACKNOWLEDGEMENTS

We have provided the information in this Affidavit for use by the Fund for the sole purpose of determining our eligibility for domestic partnership coverage. No third parties shall have any rights under this Affidavit.

Property and Other Implications: Please be advised that some courts have recognized non-marriage relations as the equivalent of marriage for the purpose of establishing and dividing joint property. You are urged to seek appropriate legal advice before signing this affidavit.

_____

_____

_____

PROOF OF RESIDENCY AND FINANCIAL INTERDEPENDENCE

Qualified domestic partners must prove that they have resided together for at least six months prior to the submission of this affidavit and that they are currently financially interdependent. Any dependent children being enrolled for coverage have also met this residency and financial interdependence requirement.

Check each document that is being presented.

1.) Required of Both Individuals:
☐ State-issued drivers license or state-issued ID card showing the same address for both individuals
2.) Required of All Dependents:
☐ Social Security card or Individual Taxpayer Identification Number (ITIN)
3.) Plus Any <u>Two</u> of the Following (Showing Both Persons' Names):
☐ Jointly executed lease or mortgage loan, property title or other joint real estate holdings ☐ Evidence of joint applicants/signers of a commercial loan, other than mortgage ☐ Executed wills naming each other as beneficiary, noting relationship ☐ Evidence of Joint ownership of an automobile
➥ **If only <u>one</u> of the four items identified in section 3 directly above can be provided, then <u>two</u> of the following are required:** ☐ Joint utility bill, evidencing the same name and address of both individuals with a service location of the same address ☐ Joint bank account ☐ Joint Credit Card
☐ Same-sex partners providing evidence of legal marriage in a state recognizing same-sex marriage may provide evidence of such marriage, along with items number 1 and 2 in order to satisfy their application requirements. Submission of these documents will eliminate your need to recertify each year. (Benefit eligibility, limitations, and exclusions for same-sex marriage will be based upon the Federal Defense of Marriage Act.)

(Please provide an original plus a photocopy of all documents. The original documents will be returned to you).

Benefits Fund Staff Use Only	
Print Name of Staff Who Has Received Above Documents	
Signature of Staff Who Has Received Above Documents	**Date** (mm/dd/yyyy)

DOMESTIC PARTNERSHIP AFFIDAVIT

We hereby submit this affidavit under sworn oath that we are domestic partners, as defined within this document, and have met or exceeded the following criteria for eligibility of benefits coverage as domestic partners under the Health Benefits Fund:

1.) We are each other's sole domestic partner and intend to remain so indefinitely.

2.) Neither of us is currently married, nor are we registered as a domestic partner of anyone else.

3.) We are at least eighteen (18) years of age and mentally competent to consent to this contract.

4.) We are not related by blood closer than that which would otherwise prohibit legal marriage in the State of New York (or in the state in which we legally reside).

5.) We currently reside together exclusively in the same residence and have done so for at least six months prior to the date we signed the original preliminary enrollment form.

6.) Our relationship is one of mutual support, caring and commitment.

7.) We are committed to each other's common welfare, are jointly responsible for common expenses and have done so for at least six months.

8.) We certify that we have read the required enrollment, re-enrollment, termination and the Fund's rules on Coordination of Benefits and agree to abide by them.

We the undersigned submit this sworn affidavit certifying that the information in this affidavit for domestic partner coverage is current, accurate and true. We further acknowledge our joint and individual obligations related to this extension of coverage and agree to fully comply with all items contained in this affidavit.

We further acknowledge that submitting false information is illegal, and that if we have supplied false information we acknowledge that we will be solely responsible for all costs associated with the provision of any and all care and services provided under the domestic partner benefit.

We have read and understand this affidavit and have been given the opportunity to ask questions regarding its content.

_____	_____
Covered Member's Printed Name	Domestic Partner's Printed Name
_____	_____
Covered Member's Signature	Domestic Partner's Signature

_____
Date

State of New York)
) ss.:
County of New York)

Subscribed and sworn to (or affirmed) before me this day of , 200 by

_____
Name of Notary

_____
Signature of Notary

STATEMENT OF DOMESTIC PARTNERSHIP TERMINATION

(This form MUST be completed and sent or presented to the Fund office *and* your Domestic Partner within fifteen (15) days of the termination of your Domestic Partnership.)

1. I, _____, (Covered Member) hereby attest to the following:

   _____ (Domestic Partner) and I are no longer domestic partners as identified in my Domestic Partnership Affidavit filed with the New York Hotel Trades Council & Hotel Association of New York City Health Benefits Fund for enrollment.

2. I make and file this Statement of Domestic Partnership Termination to cancel the Domestic Partnership Affidavit filed by me with the New York Hotel Trades Council and Hotel Association of New York City Inc. Health Benefits Fund on _____ (enter most recent enrollment date).

3. I mailed my former Domestic Partner a copy of this notice at: _____ (address) on _____ (date).

I declare, under penalty of perjury, that the above statements are true and correct.

Signature of Covered Member: _____

Printed Name of Covered Member: _____

Covered Member's Address: _____

_____

Date of Notification: _____