



305 West 44<sup>th</sup> Street | New York, NY 10036 | (212) 586-6400 | Fax: (212) 459-1699 | [www.HotelFunds.org](http://www.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 [www.HotelFunds.org](http://www.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, 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 **financially interdependent for at least six months** prior to the submission of this affidavit. Any dependent children being enrolled for coverage have also met this residency and financial interdependence requirement.

## 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 Funds' 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Currently Enrolled		
FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER		
DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Currently Enrolled		
FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER		
DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 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.

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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.***

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## 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.

**NOTE TO MEMBERS & STAFF:** Check each document that is being presented for accuracy.

<b>1.) Required of Both Individuals:</b>
<input type="checkbox"/> State-issued driver's license or state-issued ID card showing the same address for both individuals
<b>2.) Required of All Dependents:</b>
<input type="checkbox"/> Social Security card or Individual Taxpayer Identification Number (ITIN)
<b>3.) Plus Any <u>Two</u> of the Following (Showing Both Persons' Names):</b>
<input type="checkbox"/> Jointly executed lease or mortgage loan, property title or other joint real estate holdings
<input type="checkbox"/> Evidence of joint applicants/signers of a commercial loan, other than mortgage
<input type="checkbox"/> Executed wills naming each other as beneficiary, noting relationship
<input type="checkbox"/> Evidence of Joint ownership of an automobile
<b>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:</b>
<input type="checkbox"/> Joint utility bill, evidencing the same name and address of both individuals with a service location of the same address
<input type="checkbox"/> Joint bank account
<input type="checkbox"/> Joint Credit Card

(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)



**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: \_\_\_\_\_