American Lung Association.

Domestic Partnership Affidavit

The American Lung Association "Association" provides benefits to your domestic partner and his or her children, provided that you and your domestic partner complete and sign this Domestic Partnership Affidavit in the presence of a Notary Public and return it along with the supporting documentation to Human Resources.

Employee Name (print)	Domestic Partner Name (print)

We declare that we are domestic partners in accordance with the following criteria:

- We are each other's sole domestic partner.
- Neither of us is legally married to anyone.
- Each of us is at least eighteen (18) years old and mentally competent to consent to this contract.
- We are not related by blood to a degree of closeness that would prohibit legal marriage in this state.
- We reside in the same household.
- We are jointly responsible for each other's common welfare and shared financial obligations and have been so for at least six (6) months prior to the date of this Affidavit. This may be demonstrated by the existence of three of the following. (We have noted below the types of documentation that we are attaching.)

  ☐ Domestic Partnership Agreement
  ☐ Joint mortgage or lease
  ☐ Designation of domestic partner as beneficiary for life insurance
  ☐ Designation of domestic partner as beneficiary for retirement contract
  ☐ Designation of domestic partner as primary beneficiary in the employee's will or of employee in the domestic partner's will
  ☐ Durable property and health care powers of attorney
  ☐ Joint ownership of motor vehicle
  ☐ Joint bank account

CERTIFICATION OF TAX STATUS

If you enroll an eligible domestic partner or an eligible child of your domestic partner for medical, dental, or vision coverage, please keep in mind that if the individual is **not** an IRS tax dependent for purposes of health coverage, the value of the Association-provided coverage for the individual will be reported as taxable income to you, a concept known as imputed income. In addition, you will pay your share of the contribution for his or her coverage on an after-tax basis.

Domestic Partner or Partner's Child — Federal Tax Status. Your domestic partner or a child of your domestic partner may be your federal tax dependent for purposes of his or her health coverage by meeting the requirements to be a dependent for health coverage purposes under the Internal Revenue Code of 1986. Your domestic partner or a child of your domestic partner may be your Qualifying Relative for purposes of health coverage if he or she is a U.S. citizen or resident and:

1. receives over one-half of his or her support from you for the calendar year;
2. lives with you for the entire calendar year as a member of your household; and
3. is not any other taxpayer's "qualifying child" for federal tax purposes during the calendar year.

A Note Regarding Your Domestic Partner's Child: If a child covered as an eligible dependent under your medical, dental or vision benefits is your child, adopted child, or eligible foster child, he or she automatically qualifies for tax-free benefits until age 26. Other limitations on eligibility for benefits may apply.

If you have questions about whether or not your domestic partner or your domestic partner's child qualifies as a dependent for tax-free health coverage or need additional information, you should consult your tax professional.

I, _____ (employee), acknowledge and understand that benefits provided to my domestic partner and/or the children of my domestic partner will be treated as taxable income to me for federal, state, and local tax purposes unless my domestic partner and/or the children of my domestic partner qualify as dependents under Section 152 of the Code, as modified for health coverage purposes. I have read the information above and have had an opportunity to consult a tax advisor. I understand that falsely certifying dependency status could result in disciplinary action at the Association, including termination of employment.

Relationship	Full Name	This person **qualifies** as my federal tax dependent for health coverage	
Domestic Partner		☐ Yes	☐ No
Child		☐ Yes	☐ No
Child		☐ Yes	☐ No
Child		☐ Yes	☐ No
Child		☐ Yes	☐ No

CHANGE IN DOMESTIC PARTNERSHIP

- I, _____ (employee), agree to notify Human Resources if there is any change in our status as domestic partners (for example, a change in legal status, joint residence, or shared financial responsibility) as certified in this Affidavit that would make my domestic partner no longer eligible for any of the Association's benefits. I will notify the Human Resources within 30 days of such change by submitting a notarized statement documenting the end of the domestic partnership and the effective date of the event.

- After such termination, the individual employed by the Association cannot submit a subsequent Domestic Partnership Affidavit until twelve (12) months after the notarized statement documenting the end of the domestic partnership was executed.

ACKNOWLEGEMENTS

- We have provided the information in this Affidavit for the sole purpose of determining our eligibility for the Association-provided domestic partner benefits. We understand that this information will be held confidential insofar as the law allows and will otherwise be subject to disclosure only upon our expressed written authorization.
- We understand that enrollment of a domestic partner and his/her dependent children in certain benefit plans will have tax implications for the employee.
- We understand that any false or misleading statements made in order to receive benefits for which we do not qualify may subject the individual employed by the Association to loss of benefits, an obligation to reimburse the Association for any costs involved in providing benefits coverage, and disciplinary action, including termination of employment.
- We understand that the Association reserves the right to amend or terminate any of its policies, guidelines, practices or benefit plans at any time.
- We acknowledge the Association's advice that we consult with a legal advisor before signing this document.

_____
Employee Signature & Date

Subscribed and sworn to before me this ____ day of _____, 20__.

_____
Domestic Partner Signature & Date

_____
Notary Public