CITY OF MADISON
CERTIFICATION OF DOMESTIC PARTNERSHIP
FOR HEALTH PREMIUM REIMBURSEMENT PROGRAM
AMFS, AMPS, IAFF 311, and MPPOA Employees Only

Employee Information

Name:	**Munis ID #:**
Date of Birth:	**Department:**

Domestic Partner Information

Name:	**Date of Birth:**
Employer:	
Employer Address:	

Employee Certification

By my signature, I certify that I am in a domestic partner relationship with the above named individual (Domestic Partner) that satisfies the requirements of the City of Madison's Domestic Partner Health Insurance Premium Reimbursement Program (hereafter referred to as "the Program"). I further certify that I will notify the City of Madison Human Resources Department within 30 days if my relationship ceases to satisfy the requirements of the Program, by completing and submitting a City of Madison Termination of Domestic Partnership form.

DOMESTIC PARTNER HEALTH INSURANCE PREMIUM REIMBURSEMENT PROGRAM
ELIGIBILITY REQUIREMENTS

The certifying employee must meet all of the following requirements in order to be eligible for a reimbursement of eligible health insurance premium expenses incurred by the employee's Domestic Partner:

The employee and the employee's Domestic Partner are each other's Domestic Partner in accordance with the following criteria and are eligible for the Program as Domestic Partners.

1. The employee and domestic partner are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the immediate future; and
2. Are not related by blood closer than would bar marriage in the state of Wisconsin; and
3. Are not married or legally separated and if either party has been a party to an action or proceeding for divorce or annulment, at least six (6) months have elapsed since the date of the judgement terminating the marriage; and
4. Neither domestic partner is currently registered in a domestic partnership with a different domestic partner and, if either partner has previously been registered as a domestic partner in a domestic partnership, at least six (6) months have elapsed since the effective date of termination of that registration; and
5. Are each 18 years of age or older; and
6. Are each competent to contract; and
7. Are occupying the same dwelling unit as a single, nonprofit housekeeping unit, whose relationship is of permanent and distinct domestic character; and
8. Are not in a relationship that is merely temporary, social, political, commercial, or economic in nature; and

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9. Are jointly responsible for each other's common welfare and share financial obligations which could be demonstrated upon request by providing proof of the existence of (please check):
   A. Designation of Domestic Partner as primary beneficiary in either:
      - ☐ my or my Domestic Partner's will, or
      - ☐ life insurance, or
      - ☐ retirement plan

   OR

   B. Two (2) of the following:
      - ☐ Joint mortgage or lease or other appropriate written evidence of common residence such as joint utility bills
      - ☐ Durable power or health care power of attorney
      - ☐ Joint ownership of motor vehicle
      - ☐ Joint checking account or joint credit account

Acknowledgment

I understand that this benefit is premised on the fact that my domestic partner does **not** have access to **any** employer sponsored (i.e., where the employer would pay at least 50% of the total monthly premium) health insurance program from another source. Any such access must be reported immediately and will serve to negate my domestic partner's eligibility for this benefit.

I understand that the benefits I elect for my Domestic Partner using the registration will remain in effect as long as I remain an active City employee and continue to meet the health insurance eligibility requirements or until alternative health insurance coverage is provided through the State of Wisconsin Insurance Board and that the percentage level of City contribution shall be consistent with that established for me.

I understand that the filing of false, inaccurate, or misleading information, or the failure to correct any such information which may result in the repayment of unauthorized benefits, may subject the signing employee to discipline, and may result in other legal and/or financial penalties as provided by law.

I understand that the City of Madison retains the right to verify, at any time, any and/or all of the information set forth in this registration.

I understand that this registration affects only health insurance benefits. The sick leave, bereavement leave, and family leave benefits to City Employees registered with the Human Resources Department remain the same and unaffected by this registration.

I understand that it is my responsibility to periodically (not more frequently than monthly) request said reimbursement through the appropriate form available from the Human Resources Department.

Signature of Employee	**Date of Signature**
Signature of Human Resources Director	**Date of Signature**

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