JOHNSON COUNTY COMMUNITY COLLEGE
FLEXIBLE BENEFITS PLAN

AFFIDAVIT OF DOMESTIC PARTNERSHIP

We,_____and _____ certify that we are domestic partners in accordance with the following criteria and therefore eligible for Medical, Dental and/or Vision coverage under the College's benefit programs, due to the fact that:

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

2. We are jointly responsible for each other's common welfare, share financial obligations and share our primary residence. We will provide evidence of joint responsibility. Joint responsibility may be demonstrated by the existence of either (check A or B):

_____ A. A civil union licensed under state law (civil union is defined as a legally recognized union between same sex partners), or other recognized marriage under Kansas law

OR

_____ B. Two or more of the following (please check at least two items that apply):

_____1. Joint mortgage or joint ownership of primary residence.
_____2. Joint ownership of motor vehicle.
_____3. Joint checking account.
_____4. Joint credit account.
_____5. Joint lease.
_____6. The Domestic Partner has been designated as a beneficiary for employee's will, retirement contract, or life insurance.

3. We are:

- not married to anyone, and
- each at least eighteen (18) years of age, and
- mentally competent to consent to contract, and
- not related by blood to a degree of closeness, which would prohibit marriage in the State of Kansas.

We understand that domestic partners are subject to the other eligibility provisions of the College's benefit plans, including the fact that all new employment, birth or adoption of children, marriages, and domestic partnership are all subject to a thirty-one (31) days enrollment period limit from the date of eligibility. No individual may have coverage as both an employee and a dependent or as a dependent of two individuals covered under the health plan.

To the extent that coverage under the health plan for a domestic partner is at all financed by the College and such domestic partner is not certified as a qualifying tax dependent as set forth below, the employee agrees that he or she shall be taxed on the fair market value of the coverage being paid for the domestic partner by the College. Fair market value is based on what the employee's cost would have been for the same coverage at group rates. The value of the coverage must be reported as income on the employee's W-2 Form and the College must withhold Federal Insurance Contribution Act (FICA) on that imputed income. Nontaxable health coverage can only be provided to an employee's legal spouse or a dependent as defined under Sec. 152 of the Internal Revenue Code.

The employee agrees to notify the College in writing within thirty-one (31) days of any legal termination of our domestic partnership, and will submit a written Termination of Domestic Partnership form for that purpose.

We certify that the foregoing is true and correct.

I, the undersigned employee of the Johnson County Community College and my Domestic Partner, understand that falsification of information contained in this Affidavit may lead to disciplinary action, up to and including immediate termination of employment, and may subject us to civil action to recover any losses, including reasonable attorney's fees, in addition to an obligation to repay benefits received.

Note: Signing of this Affidavit may affect important legal rights. Please consult your attorney.

Signature of Employee:_____ Date: _____

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Certified, subscribed and sworn to before me this _____day of _____. 20_____

STATE OF KANSAS

County of _____ _____
Notary Public

[SEAL] My commission expires: _____

Signature of Domestic Partner:_____ Date: _____

Certified, subscribed and sworn to before me this _____day of _____. 20_____

STATE OF KANSAS

County of _____ _____
Notary Public

[SEAL] My commission expires: _____

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THE FOLLOWING SHALL ONLY BE COMPLETED BY EMPLOYEES WITH A QUALIFIED TAX DEPENDENT—PLEASE CONSULT YOUR OWN TAX ADVISOR

Partner and/or Partner's Child(ren) Certification as a Tax-Qualified Dependent (If Applicable)

Based on consultation with a tax advisor, I certify that the [ ] Partner and/or [ ] Child(ren) whom I am enrolling for coverage is my legal tax dependent under IRS Sec. 152. I understand that falsification of this certification of dependency status may result in disciplinary action, up to and including immediate termination of employment, as well as potential charges of tax fraud. I agree to notify the College immediately of any change in this tax status.

Signature of Employee:_____ Date: _____