

AFFADAVIT OF DOMESTIC PARTERSHIP

I,	(print name of Employee) certify that
	(print name of Domestic Partner) and I reside together at:
	(address).
under the Heal	e information in this Affidavit for the sole purpose of determining our eligibility for domestic partner benefits Ith Professions of Montana Plan & Trust (the "Plan").
We hereby atte	est that we meet the following requirements for domestic partnership in accordance with the Plan:
 We ha Neithe 	e both eighteen (18) years of age or older and are competent to enter into a contract; ve shared the same primary residence for at least the last 12 consecutive months; r of us is married;
5. We are	r of us is a domestic partner of anyone else; e not related to each other as determined by the laws of our state of residence; and e responsible for each other's common welfare and have a financially interdependent relationship.
Attached are o	ne or more of the following documents (check to designate documents attached to this Affidavit):
☐ No	otarized copy of lease naming both domestic partners;
☐ Ev	ridence of joint savings or joint checking account that has been in effect for at least 6 months;
☐ Tit	le and registration of joint ownership of an automobile;
☐ De	esignation of each other as primary beneficiary in wills, life insurance policies or retirement annuities;
☐ Ev	ridence of joint use and liability for credit cards;
Се	ertified copy of Employee's life insurance policy naming domestic partner as the beneficiary;
☐ Ev	ridence that domestic partner is a beneficiary under Employee's deferred compensation or retirement plan.
	derstand that the Plan may request any or all of the above documents, in addition to the documents ed, as proof of financial interdependence.

Notice of Change in Status:

We agree to notify the Plan (or its designated third-party administrator) within 30 days of any change in the circumstances, documents or information provided in or with this Affidavit. We understand that, if such change results in the termination of domestic partnership benefits, as determined by the Plan in its sole discretion, and we fail to give accurate and timely notice, then the Employee will be financially responsible to reimburse the Plan for any benefits provided by the Plan to the (former) domestic partner.

Acknowledgement Regarding False Statements:

We understand that any person, including the Plan, who suffers any loss because of a false statement contained in this Affidavit, or because of a breach of our obligations under this Affidavit, may bring a civil action against us to recover their losses including reasonable attorneys' fees.

Recognition of Tax and COBRA Rules.

We are aware that a domestic partner is not the same as a legal spouse (including a common-law spouse or a same-sex spouse) for tax purposes, and that children of a domestic partner may not qualify as dependents of the Employee under Section 152 of the Internal Revenue Code. We further understand that the termination of domestic partnership is not a qualifying event under the COBRA continuation coverage laws, if applicable to the Employer.

We affirm under penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge.

Signature of Employee	Date	_
Date of Birth		
Signature of Domestic Partner	Date	_
Date of Birth		
Subscribed and sworn befor	re me this day of	, 20
	Notary Public of the State of Montana	
	Printed Name of Notary	
(NOTARY SEAL)	Residing at	
(1101/111/102/12)	Date My Commission expires:	