

Certification of Same-Sex Domestic Partnership

For the purpose of obtaining benefits under the Nonappropriated Fund (NAF) Health Benefits Program, I _____ declare that _____ (*print full name of same-sex Domestic Partner*) and I are in a committed relationship between two adults, of the same sex, in which we:

1. Are each other's sole domestic partner and intend to remain so indefinitely;
2. Maintain a common residence, and intend to continue to do so (or would maintain a common residence but for an assignment abroad or other employment-related, financial, or similar obstacle);
3. Are at least 18 years of age and mentally competent to consent to contract;
4. Share responsibility for a significant measure of each other's financial obligations;
5. Are not married or joined in a civil union to anyone else;
6. Are not a domestic partner of anyone else;
7. Are not related in a way that, if we were of opposite sex, would prohibit legal marriage in the U.S. jurisdiction in which we reside; and
8. Are willing promptly to disclose any dissolution or material change in the status of the domestic partnership.

I also agree to, and understand that:

1. I have an obligation to notify _____ (*Installation Name*) of the dissolution of this domestic partnership by filing a Declaration of Termination of Same Sex Domestic Partnership. I will notify _____ (*Installation Name*) no later than 30 days after the death of my domestic partner or the date of dissolution of the domestic partnership.

2. As part of the enrollment process, or during an eligibility audit, _____ (*Installation Name*) may require documentation to establish interdependency.

3. Willful falsification of any documentation required to establish that an individual is in a domestic partnership may lead to disciplinary action, loss of entitlements, and/or recovery of the cost of benefits received related to such falsification, as well as constitute a criminal violation under 18 USC §1001.

I affirm that the statements in this Declaration are true and correct.

Employee (or Retiree) signature Date: _____ Active DOB: _____
MM/DD/YYYY Retired MM/DD/YYYY

Employee (or Retiree) and Domestic Partner Address: _____
Street Name

City, State & Zip Code

PRIVACY ACT STATEMENT: Authority for collection of this information is 5 U.S.C. Section 6311 and E.O. 9397. The purpose for which the information will be used is to administer and process claims for benefits and allowances based on family members. The information provided may be disclosed as generally permitted under 5 U.S.C. Section 552a(b) of the Privacy Act, as amended. Providing this information is voluntary, however, failure to supply the required documentation may result in the denial of part or all of your claim.