

School of Medicine

**COMPLETE ONLY IF ENROLLING SPOUSE OR SAME-SEX DOMESTIC PARTNER FOR HEALTH INSURANCE
AND/OR DENTAL INSURANCE**

**JOHNS HOPKINS UNIVERSITY
AFFIDAVIT OF MARRIAGE/SAME-SEX DOMESTIC PARTNERSHIP**

I, _____ SSN _____ - _____ - _____ certify that I and
Name of Subscriber (print)

(Complete either "A" or "B"):

"A" _____ SSN _____ - _____ - _____ were legally
Name and SSN of Spouse (print)
married on ___/___/_____

-OR-

"B" _____ SSN _____ - _____ - _____ became
Name and SSN of Same-sex Domestic Partner (print)
same-sex domestic partners on ___/___/_____, and we certify the following to be true:

1. We are committed as a family in a long-term relationship of indefinite duration and are socially, emotionally, and financially interdependent with each other in an exclusive mutual commitment in which we agree to be responsible for each other's common welfare and share financial obligations; and
2. we are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which we legally reside and our relationship does not violate state or local law; and
3. we agree to notify Johns Hopkins University School of Medicine Registrar's Office if there is any change in our status of marriage or domestic partnership as certified in this statement within thirty days of that change by filing a Marriage/Same-sex Domestic Partnership Termination Form; and
4. we were competent to consent to contract when our marriage or domestic partnership began; and
5. we understand that any marriage or domestic partnership recognized by the University based on this affidavit will be treated as terminated for benefits purposes upon the death of my spouse/domestic partner or on the date indicated in a Marriage/Same-sex Domestic Partnership Termination Form submission (or, if earlier, on the date of divorce or legal separation of a legal marriage); and
6. we understand that benefits provided by Johns Hopkins University School of Medicine for a domestic partner or a child of a domestic partner generally will be subject to federal (and possibly state) income tax withholding and also to Social Security and Medicare taxes based on the fair market value of those benefits and any employee contributions for coverage for those benefits must be made on an after-tax basis unless the subscriber signs the statement at the end of this Affidavit to certify that the partner or child qualifies as a Section 152 Dependent (as described later in this Affidavit) of the subscriber for tax purposes; and
7. we understand that this information will be held confidential but is subject to disclosure for administrative purposes, as required by law or upon our express written authorization; and
8. we understand that any person's eligibility for benefits is subject to auditing by Johns Hopkins University School of Medicine and its agents for verification purposes; and
9. we understand that legal implications under state and/or federal law may exist due to the declaration of responsibility for our common welfare; and
10. we understand that if we make a false statement or misrepresentation on this Affidavit of Marriage/Same-sex Domestic Partnership, the University reserves the right to take any and all actions necessary to deny benefits or to recover amounts paid for benefits to which a person was not entitled, as well as any expenses or attorney fees incurred by the University in an attempt to recover such amounts and that any false statements on this Affidavit may lead to other disciplinary action, up to and including termination of employment.
11. we understand that completing this Affidavit is only one requirement for certain benefits and that all eligibility requirements and other provisions of all benefit plans as well as policy provisions of University programs will also apply.

(OVER)

School of Medicine

Subscriber's Signature: _____ Date: ___/___/___

Print Name of Subscriber: _____

Spouse/Domestic Partner's Signature: _____ Date: ___/___/___

Print Name of Spouse/Same-sex Domestic Partner: _____

This form must be returned in order to complete the health insurance and dental insurance enrollment process. Return the completed form to:

Johns Hopkins University School of Medicine
Office of the Registrar
Miller Research Building, Suite 147
733 N. Broadway
Baltimore, MD 21205-2196

NOTE: You should review the definition below and sign the statement below if you intend to elect any type of coverage for your domestic partner or any child of your domestic partner, if you conclude that your partner or your partner's child is your dependent for tax purposes.

Internal Revenue Code Section 152 Definition of Dependent

For purposes of the University's School of Medicine benefits, a domestic partner generally will be your dependent under Internal Revenue Code section 152 (referred to as "Section 152 Dependent" in this Affidavit) only if you provide over one-half of your partner's financial support and your partner lives with you during the entire tax year. A child of your domestic partner who is not your adopted or biological child generally will qualify as your Section 152 Dependent for purposes of these benefits for a tax year only if (1) you provide over one-half of the child's support, (2) the child lives with you and (3) neither your domestic partner nor any other taxpayer claims the child as a dependent for federal tax purposes. Additional rules and restrictions may apply. You should consult with a tax adviser if you have any question about whether your domestic partner or a child qualifies as your dependent for tax purposes.

If your domestic partner or any child of a domestic partner qualifies as a Section 152 Dependent for purposes of medical, dental, and personal accident benefits and you do not want to be taxed on the value of any of those benefits provided to your domestic partner or a child of a domestic partner, you must complete the following:

By signing below, I certify that I have reviewed the requirements for a domestic partner or a child of a domestic partner to be treated as my Section 152 Dependent for purposes of the Plan and that the following person or persons (*check appropriate box or boxes*):

- my domestic partner
- the following child or children of my domestic partner (*list by name*):

qualify as my Section 152 Dependents for purposes of the Plan's health or dental benefits. I agree to promptly inform the School of Medicine if any person indicated above ceases to qualify as my Section 152 Dependent while covered under any of these benefits.

Subscriber's Signature: _____ Date: ___/___/___