BOARD OF DIRECTORS:
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VICE PRESIDENT
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SECRETARY
Neil Kueffer
EXECUTIVE DIRECTOR

Dear Retiree,

As you requested, the enclosed documentation is for your review and completion to enroll a domestic partner into the Retiree Health Care Authority insurance plans.

Important things to know about domestic partners:

- Domestic partners are enrolled similarly to spouses.
- The affidavit that is included with this mailing needs to be signed, by both the retiree and domestic partner, and notarized.
- If there is a termination of a domestic partnership, the retiree must notify NMRHCA in writing within 31 days of terminating the domestic partnership.
- Dependents of domestic partnerships are eligible for benefits.
- We also *may* ask for other written proof of the domestic partnership or dependents.

Please return the Affidavit of Domestic Partnership and Change Request Form to the New Mexico Retiree Health Care Authority ASAP.

Please feel free to contact us at the numbers listed below with any questions or concerns that you may have.

Thank you,

New Mexico Retiree Health Care Authority

6300 JEFFERSON ST. NE, SUITE 150 - ALBUQUERQUE, NM 87109-3482 - TOLL FREE 800.233.2576
EMAIL: CUSTOMERSERVICE@RHCA.NM.GOV - FAX: 505.884.8611 - WEBSITE: WWW.NMRHCA.ORG

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

BOARD OF DIRECTORS:
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AFFIDAVIT OF DOMESTIC PARTNERSHIP

As required by NMAC 2.81.5(C), this affidavit must be used to apply for domestic partner benefits and must be filed with the New Mexico Retiree Health Care Authority.

A. DECLARATION OF DOMESTIC PARTNERSHIP

I, ___________________________________, declare that I am in a domestic partnership with
(PRINT Retiree's Name)

____________________________________. Further, we declare that:
(PRINT Domestic Partner's Name)

1. We are in an exclusive and committed relationship for the benefit of each other, and our relationship is the same as, or similar to, a marriage relationship in the State of New Mexico.
2. We share and have shared together for 12 or more consecutive months a common, primary residence.
3. We are jointly responsible for each other's common welfare and we share financial obligations.
4. Neither of us is married or a member of another domestic partnership.
5. We are both at least 18 years of age.
6. We are both legally competent to sign this Affidavit of Domestic Partnership.
7. We are not related by blood to a degree of closeness that would prevent us from being married to each other in the State of New Mexico.

B. BENEFITS FOR THE ELIGIBLE DEPENDENTS CHILDREN OF THE DOMESTIC PARTNER

Domestic partner benefits are also available to the domestic partner's children, provided, however, that the child is primarily dependent upon the employee or domestic partner for support and is an eligible dependent child because:

1. Either of the domestic partners is the biological parent of the child;
2. Either or both partners are adoptive parents of the child; or
3. The child has been placed in the Domestic Partners' household as part of an adoptive placement, legal guardianship, or by court order (excludes foster children).

We declare that the following named individual(s) is/are eligible dependent child(ren) (as defined by NMSA 10-7C-4(F)):

____
(For each Eligible Dependent Child, list the child's name and describe the relationship to the Domestic Partner)

____

____

____

C. EXCLUSIONS

Except for the eligible individuals named in Section B above, the following persons are not covered by Domestic Partner benefits and are not considered eligible dependents: parents, foster children, ex-spouses and ex-domestic partners, mere roommates, and other relatives who are related to the state employee to such degree of closeness that marriage would be prohibited in the State of New Mexico.

D. ACKNOWLEDGEMENTS

1. By signing this Affidavit of Domestic Partnership, we agree to notify the NM Retiree Health Care Authority in writing within 31 days (a) of any change in our status as domestic partners when any of the items in the Declaration of Domestic Partnership (paragraph A above) no longer apply, (b) because we wish to terminate our domestic partnership (termination notice must be done in writing), or (c) in the event a dependent ceases to meet the eligibility requirements for benefit coverage.

2. We understand that the NM Retiree Health Care Authority will pay its portion of the premium on the domestic partner's and dependent benefits, if any, in the same proportion as is paid for similar benefit premium portions paid for spouses and dependents of married persons covered by the retiree's benefits program, and that the retiree is required to pay their portion of the premium on the domestic partner's and dependent benefits, if any, in the same proportion as is required for similar benefit premium portions that married retirees pay for spouses and dependents.

3. We acknowledge that we are hereby advised to seek competent legal advice about present and future financial obligations we may be undertaking before we sign this Affidavit of Domestic Partnership.

4. We understand that at any time we may be requested in writing by the NM Retiree Health Care Authority to provide reasonable written proof that we are jointly responsible for the common welfare of each other, that we share financial obligations, and/or to show that the named dependents, if any, are eligible for benefits coverage, and that if we fail to provide such requested proof, then the domestic partner or dependent benefits can be denied or terminated.

5. WE UNDERSTAND THAT ANY MISREPRESENTATION OF FACT IN THIS AFFIDAVIT OF DOMESTIC PARTNERSHIP MAY RESULT IN LOSS OF BENEFITS AND/OR DISCIPLINARY ACTION, AND THAT AS A RESULT OF SUCH MISREPRESENTATION THE RETIREE MAY BE REQUIRED TO REIMBURSE NMRHCA FOR ANY COST FOR PROVIDING BENEFIT COVERAGE OR FOR PROVIDING THE ACTUAL BENEFITS, SUCH COSTS INCLUDING, AMONG OTHER THINGS, ATTORNEY'S FEES.

E. NOTARIZATION

We affirm, under penalty of perjury, that the assertions in this Affidavit of Domestic Partnership are true and correct. *(Both partners must sign this legal document in the presence of a Notary Public.)*

____

Signature of Retiree (Print Retiree's Name)

____

Signature of Domestic Partner (Print Domestic Partner's Name)

____

Common Residence Address City State Zip Code

____

Mailing Address City State Zip Code

STATE OF NEW MEXICO)
)
COUNTY OF ____________________)
(County Name)

SUBSCRIBED AND SWORN to this _________ day of ________________, by

______________________________, an eligible retiree with the NM Retiree Health Care Authority, and
(Print Retiree's Name)

______________________________, the retiree's Domestic Partner.
(Print Domestic Partner's Name)

____
Notary Public
My Commission Expires: