MORAVIAN
UNIVERSITY

Certification of Domestic Partnership

I. Eligibility

We, _____ (a Moravian employee), and

_____(domestic partner), are Domestic Partners as defined by the following criteria:

1)We share the same permanent residence and have done so for at least twelve (12) months prior to applying for Domestic Partner benefits;

2)We have an exclusive mutual commitment;

3)We are financially interdependent for each other's welfare and debts to third parties. Evidence of this interdependency can be demonstrated by three (3) documents as outlined below. We understand and acknowledge that the College can, at any time, request confirmation of ongoing financial interdependence.

a) A copy of a domestic partnership agreement;

b) Evidence of joint purchase of a home;

c) A copy of a lease for a residence identifying both parties as responsible for payment of rent;

d) Evidence of a joint checking account;

e) Evidence of a joint savings account;

f) A title for a car showing joint ownership;

g) Evidence of joint liability for credit cards;

h) A copy of the form specifying that the domestic partner is the beneficiary of life insurance;

i) Evidence that the domestic partner is the beneficiary of the employee's retirement account;

j) Evidence of durable powers of attorney for property or health;

k) Wills specifying the domestic partner as the major recipient of employee's financial assets.

4) Neither of us is married to anyone else nor has another Domestic Partner;

5) Each of us is eighteen (18) years of age or older and competent to consent to a contract including incurrence of those contractual obligations which may rise out of the domestic partnership.

6) We are not related by blood closer that would bar marriage in the state of our residence; and

7) We affirm under oath, that the assertions set forth above are true to the best of our knowledge.

II. Change in Domestic Partnership

1. We agree to notify the Office of Human Resources if there is any change in our status as Domestic Partners as certified in this statement which would make the Domestic Partner no longer eligible for health benefits (i.e., a change in the Domestic Partner's permanent residence or if we no longer are each other's sole Domestic Partner). We will notify the Office of Human Resources within thirty (30) days of such a change by filing a Statement of Termination of Domestic Partnership. The Statement of Termination shall affirm that the domestic partnership status is terminated as of its date of execution and that a copy of the Statement of Termination has been mailed to the other party by the party authorizing such action.

2. After such termination, I, _____the undersigned Moravian College employee, understand that a subsequent Statement of Domestic Partnership cannot be filed until twelve (12) months after a Statement of Termination has been filed with the Office of Human Resources.

3. In the event the partnership ends, the non-employee partner may opt to be covered by COBRA to the extent allowed by law in a full premium individual plan, at his or her expense, plus a 2% administration fee.

III. Acknowledgements

1. I, the undersigned Moravian College employee, understand that under current IRS regulations, unless my Domestic Partner qualifies as my legal tax dependent, if a benefit is paid by the Institution on behalf of my Domestic Partner, it would be considered taxable income to me and will be subject to income and other applicable employment taxes. I understand that I should consult with my tax advisor regarding this issue.

2. We understand that we are responsible for any costs that fall outside of the healthcare benefit (those costs that are typically the responsibility of the insured) and the College is not liable for any payment in such circumstances.

3. I, the undersigned Moravian College employee, understand that the insurer may require information that may be different from that required as part of Institutional Policy, and as such I may be required to submit such information in order to meet the requirements of the insurer. In areas where the institutional

conditions or terms may be more rigorous than that of the insurer, the institutional conditions and terms will prevail.

4. I, the undersigned Moravian College employee, understand that any false or misleading statements made in order to receive benefits for which I do not qualify may subject me to disciplinary action up to and including termination of employment.

5. We understand that any person, company, employer or creditor who suffers a loss because of a false statement contained in the "Certification of Domestic Partnership" may bring a civil action against us/me to recover losses they may incur.

6. I, the undersigned Moravian College employee, understand that commencement of coverage for Domestic Partners will be subject to the same window period (first day of next month following eligibility and application for coverage) which governs all others who are eligible for coverage.

_____

Employee Name (Please print)

_____

Employee Signature / Date

_____

Domestic Partner Name (Please print)

_____

Domestic Partner Signature / Date

_____

Domestic Partner Social Security Number

_____

Employee and Domestic Partner Permanent Address

_____

Director of Human Resources / Date