

Spackenkill Teachers' Association Benefit Trust



Application for Continuation of Domestic Partnership

The undersigned declare as follows:

We are both eighteen years of age or older and unmarried.

We are not related by blood in a manner that would bar marriage under laws of the State of New York.

We are each other's sole domestic partner, and have been so for at least twelve (12) months prior to the date of submitting this application. We are in a relationship of mutual support, caring and commitment, and have assumed responsibility for each other's welfare.

Neither of us has been enrolled as a member of another domestic partnership within the last twelve (12) months.

I, the enrollee, affirm that I will file a Termination of Domestic Partnership within 14 days of the date I/my partner no longer meet one or more of the qualifying criteria.

I, the enrollee, understand that any false or misleading statement made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my partner and/or legal actions appropriate for the prosecution of insurance fraud.

Print Name (enrollee)

Print Name (partner)

Address

Address

Address

Address

Signature

Signature

Resubmit this form yearly to Bob Bowler by June 30th
Bob Bowler
40 Woodland Dr.
Salt Point, NY 12578