

SPACKENKILL T.A. BENEFIT TRUST : DOMESTIC PARTNER APP.
SUPPLEMENT

I (Print Teacher's Name): _____ am requesting benefits from the Spackenkill Teachers Association Benefit Trust for my domestic partner. I certify that I have applied for and been approved for medical benefits from the District.

Our Domestic Partnership began on: (Month, Day and Year) _____

Partners full name (Print): _____

Date of birth: _____

Social Security Number: _____

The above named teacher has been granted medical insurance for their Domestic Partner

Partner's Name: _____

Effective date: _____

District Official's Signature : _____

Today's date: _____