PORTLAND COMMUNITY COLLEGE
CERTIFICATE OF DOMESTIC PARTNERSHIP

Both the employee/retiree and the domestic partner must sign Section I, Certification of Partnership. The employee/retiree must sign subsequent sections regarding eligibility for PCC benefits.

Section I. Certification of Partnership

I, ___________________________(your name) and ___________________________(name of domestic partner) hereby certify that we are domestic partners and we further certify that:

1. We are each 18 years of age or older;
2. We share a close personal relationship and are responsible for each other's common welfare;
3. We are each other's sole domestic partner;
4. We are not legally married to anyone nor have had another domestic partner within the previous 31 days;
5. We are of the ☐same sex ☐opposite sex.
6. We are not related by blood closer than would bar marriage in the state issuing the contract;
7. We have shared the same regular and permanent residence as of ______________________(Date)
8. We are jointly financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and medical expenses. Note: Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost;
9. We were mentally competent to consent to contract when our domestic partnership began.
10. We also certify under penalty of perjury under the laws of the state issuing the contract that the foregoing is true and accurate to the best of our knowledge.

_________________________________ Signature of Employee/Retiree

_________________________________ Signature of Domestic Partner

_________________________________ Date

_________________________________ Date

Section II. Benefits Eligibility

This Certificate is being submitted to permit my domestic partner to participate in:

☐ PCC Health/Dental Insurance Program
☐ PCC Tuition Waiver Program
☐ _______________ Other (Please specify)

Health/Dental insurance participation requires that you complete a Benefit Enrollment Form.

1. I understand that my domestic partner is eligible for enrollment during the first 31 days of eligibility after execution of this certificate or based on the late or open enrollment provisions of PCC's group insurance contract if my partner did not enroll when initially eligible. I further understand that the children of my domestic partner are are eligible, subject to the dependent eligibility restrictions of the group insurance plan
2. I understand all are governed and regulated by the requirements and eligibility provisions applicable to dependent coverages except as provided otherwise in this certification. .
3. Coverage for the domestic partner shall terminate upon any change in circumstance attested to in Section One of this Certificate and I agree to notify the PCC Benefits Department within 30 days if there is any change of circumstances attested to in this Certificate. I understand that I may be required to reimburse the college for the value of any benefits received or paid after termination of the partnership.
4. After such termination, I understand an application to add a new domestic partner for health/dental and life insurance coverage cannot be filed earlier than 31 days from the filing of a Statement of Termination of Domestic Partnership

Section III. Tax Implications

Under applicable federal income tax law, and except as provided in the next section, the value of the benefit(s) provided to an employee for domestic partner coverage is considered taxable income and will be treated and reported as such to the IRS. Under Oregon law same-sex partner benefits are not taxable. Benefits for opposite sex partners are taxed. If your partner potentially qualifies as your dependent for tax purposes see the next section.

Section IV. Dependent Tax Exemption

The value of benefits provided to your domestic partner may be exempted from taxable income if the domestic partner qualifies as tax dependent under Section 152 of the Internal Revenue Code. To qualify for this exemption , the partner must rely on you for over half of his/her support, live in your home as his/her principal place of abode and be a member of your household. Each of these conditions must be met for each taxable year for which the exemption is claimed.

To exempt the benefit from taxation under this provision you must complete the tax dependent certification when enrolling your partner and <u>must renew the certification each year during open enrollment</u>. If you do not complete or renew the certification you will be taxed on the value of the partner's benefit as described in Section III.

I further agree to notify the college within 31 days of any change in my or my partner's circumstances that will cause my partner to no longer be claimed by me as my dependent. These circumstances include but are not limited to my dependents earning in excess of the IRS limit ($3100 for 2005) from employment and other sources.

I understand that the college has no authority or basis to approve or verify this treatment. I will indemnify and hold harmless the College from any and all financial or legal consequences if this certification is inaccurate, is not accepted by the IRS, or by my failure to promptly notify the College of a change in my or my partner's circumstances.

☐ I hereby certify that my partner qualifies and will be claimed by me as a dependent for income tax purposes under Section 152 of the Internal Revenue Code for the current year and for the foreseeable future.

______________________________ ____________________
Signature of Employee Date

Section V. Other Certifications and Signature

1. By my signature below I acknowledge and accept the terms and conditions of benefits eligibility and the tax treatment of those benefits. I understand and agree to the terms and conditions of coverage set forth in the group contract of each insurance plan or other benefit offered through my employer.
2. I understand the information contained in the Certificate will be held confidential and is subject to disclosure only upon my express written authorization or as required by law.
3. I understand a civil action may be brought against me for any losses, including reasonable attorney fees and court costs, because of a willful falsification of information contained in this Certificate of Domestic Partnership. I further understand that willful falsification of information contained in this Certificate may result in termination from enrollment under the health care plan or other benefits offered pursuant to this certification..

______________________________ ____________________ ____________________
Signature of Employee G# Date