DECLARATION OF DOMESTIC PARTNER

1 Employee Information			2 Domestic Partner Information		
First Name:	**MI:**	**Last Name:**	**First Name:**	**MI:**	**Last Name:**
School District Name:			**Date of Birth:**		**LAST 4 OF SSN #:**

3 Eligibility

I certify, as an employee of the_____(School District or Entity), and an enrolled participant in the Montana Unified School Trust (MUST) group medical benefit plan, that the above identified person meets **all** the following criteria for an eligible Domestic Partner and that I have not claimed a spouse or another Domestic Partner. The criteria below must be made available for review upon request.

NOTE: The MUST Summary Plan Description definition of a Domestic Partner provides for either opposite or same-sex partners.

The eligible Domestic Partner:

_____ A. Is at least 18 years of age;
_____ B. Has had joint ownership or joint tenancy of a residence with me for at least the most recent twelve (12) consecutive months, and the jointly-owned or jointly-leased residence has served as the primary place of residence for each of us during the same period;
_____ C. Does not meet the MUST eligibility requirements of a spouse or a dependent child;
_____ D. Does not have a parental relationship with me;
_____ E. Is not related to me by blood or marriage; and
_____ F. Has a financially-interdependent relationship with me as evidenced by at least three (3) of the following:

1. Joint ownership or lease of a motor vehicle;
2. At least one joint liability, such as a loan or credit card;
3. Mutually-granted powers of attorney or mutually-granted healthcare powers of attorney; or
4. Designation of each other as primary beneficiary in wills, life insurance policies, or retirement annuities.

Notification of Change in or Termination of Domestic Partnership

I agree that, if the domestic partnership as designated above no longer exists, I will notify my employer and the MUST Plan Administrator within 30 days of such change.

Certification

I understand all of the following:

1. The eligibility and coverage of a Domestic Partner will cease at the end of the month in which any of the above criteria (A through F) are no longer met;
2. Under federal and state law, benefit coverage of certain Domestic Partners described above may result in taxable income to the employee and may be subject to income tax withholding and applicable payroll taxes;
3. Coverage for an eligible Domestic Partner may only be activated during initial Open Enrollment, Open Enrollment, or loss of other coverage;
4. MUST must be given written notice from the employer/employee within 30 days of any change in circumstances attested to in this document;
5. Falsely or fraudulently certifying eligibility for Domestic Partner coverage or failing to inform MUST of a relevant change in eligibility requirements in any respect may result in immediate termination of coverage of the Domestic Partner and the employee and the Domestic Partner may be subject to criminal prosecution, fine, or imprisonment as provided by law; and
6. The employee will be liable for all expenditures for coverage and benefits obtained because of any misrepresentation or omission in certifying eligibility for benefit or in failing to inform MUST of a change in eligible criteria.

I further understand and acknowledge that MUST reserves the right to require copies of any or all of the above-listed documents. If I fail to provide the copies when requested, I understand that medical benefit coverage for the named Domestic Partner will be immediately terminated.

I certify and affirm that the eligibility assertions made.

_____ _____ _____ _____
EMPLOYEE SIGNATURE **DATE** **DOMESTIC PARTNER SIGNATURE** **DATE**