9500 Topanga Canyon Blvd
Chatsworth CA 91311
Tel 818-678-0040
Fax 818-477-1476
www.bscinc.com

Please see enclosed for information about adding a domestic partner during open enrollment.

(Open Enrollment is from April 24th to May 5th for a July 1st effective date)

Please contact our office if you have any additional questions by calling us at (800) 842-6635 or by email at local18@mybenefitchoices.com.

Thank you,
Local 18 Benefit Service Center
9500 Topanga Canyon Blvd.
Chatsworth, CA 91311

Enclosure

Domestic Partnership Requirements and Acceptable Proof

Adding a Domestic Partner during Open Enrollment

Dependent Type	Acceptable Documents

Registered Domestic Partner	• Certificate of Domestic Partnership issued by California Secretary of State, county, or city
	• An equivalent document issued by:
	  ○ Local California agency
	  ○ Another state, or local agency within another state

Non-Registered Domestic Partner You must have **lived together** for at least 12 months. You both must provide acceptable documentation proving you have lived together for at least 12 months. **AND** You must complete LADWP's Affidavit of Domestic Partnership confirming you and your domestic partner meet LADWP's criteria (see page 5 of this packet from LADWP's Benefit Guide for more information)	• You both will need to provide **OLD proof** (12 months or older) **AND** • **CURRENT proof** Please see acceptable proof below: • **California Driver License or identification cards** that both share the same address and issue date 12 months or older (**if this is your current address then NO other documentation is required**, if NOT, see other acceptable documents below) OR • Utility bill • Credit card statement (without personal info) • Bank statement (without personal info)

REMINDER: You'll need to remove your registered or non-registered domestic partner within 31 days of ending your domestic partnership and complete a DWP Termination of Domestic Partnership Form. If you marry your domestic partner you need to update his/her status with us and provide a copy of your marriage certificate.

ACTIVE **CONFIDENTIAL**

City of Los Angeles
Department of Water and Power

AFFIDAVIT OF DOMESTIC PARTNERSHIP
For Health Plan Enrollment Purposes Only

1. I _____ reside with my domestic partner
   Employee Name (print)

   _____ at _____
   Domestic Partner's Name (print) Address, City, Zip

   and we share the common necessities of life.

2. We have resided together in the same principal residence for at least twelve (12) months.

2a. We have resided together since _____.
   Beginning Date

3. I affirm that the effective date of this domestic partnership is _____.
   Date

4. Neither my domestic partner nor I is married to anyone else.

5. My domestic partner and I are each at least eighteen (18) years of age.

6. My domestic partner and I are not related by blood closer than would bar marriage in the State of California, and each of us is mentally competent to consent to contract.

7. Each of us is the sole domestic partner of the other and each of us is responsible for our common welfare.

8. I agree to notify the Department of Water and Power (Department) within thirty (30) calendar days of any change of circumstances attested to in this Affidavit by filing with the Department of Water and Power, Health Plans Administration Office, a Statement of Termination of domestic Partnership. Such statement of Termination shall be on a Department form provided by the Department of Water and Power, Health Plans Administration Office, and shall affirm under penalty of perjury that the partnership is terminated and that a copy of the Statement of Termination has been mailed to my former domestic partner.

9. I understand and agree that after I have filed such Statement of Termination, I cannot file another Affidavit of Domestic Partnership until twelve (12) months have elapsed.

10. I understand that if the Department suffers any loss because of a false statement contained in this Affidavit of Domestic Partnership, then the Department may bring civil action against me to recover its losses, including reasonable attorney's fees.

11. I understand and agree that I am providing the information in this Affidavit solely to allow the Department to determine my eligibility for the domestic partnership employee health plan benefits as defined by the DWP Health Plans Resolution. I understand and agree that the Department is not legally required to extend any benefits, other than benefits specifically granted

to an employee defined as a domestic partner by the City ordinance and the DWP Health Plans Resolution, as a result of my status as a domestic partner. I understand that the information provided in this Affidavit will be held confidential by the Department, but will be subject to disclosure (a) upon my express written authorization, or (b) pursuant to court order.

12. I understand that the information I am providing in this Affidavit may be used either by my domestic partner or by me as evidence of the existence of my domestic partnership relationship in subsequent legal proceedings. I understand that before signing this Affidavit, I should seek competent legal advice concerning the financial obligations I may be undertaking by signing the Affidavit.

13. I understand that I must pay income taxes on the amount of health and/or dental plan subsidy that will be paid by the Department to provide coverage for my domestic partner and/or the domestic partner's child (ren).

14. I agree that upon termination of this domestic partnership, the Department, its agents, officers, and employees are relived of any obligation to supply domestic partnership employee benefits to me under any ordinance, memorandum of understanding, or resolution, until the 12 months mentioned in No. 9 above have elapsed and until such time as another domestic partner application is submitted by me and subsequently approved by the Department.

15. I affirm, under penalty of perjury under the laws of the state of California that the assertions in this Affidavit are true to the best of my personal knowledge.

_____ _____

Signature of Employee Date

_____

Employee Number

Wet Signature Required

SPECIAL NOTES:

- *By completing this form, you are only authorizing that health benefits be extended to your domestic partner, and not retirement benefits. If you would like your domestic partner to also receive retirement benefits, you must file a separate affidavit in the Retirement Office in Room 357, (213) 367-1692.*

- *Please submit a copy of your own and your domestic partner's California Driver's License or identification card. Be advised that the addresses on your respective licenses or identification cards must match one another and be the same as your address of record with the Department of Water and Power. Your Affidavit and application cannot be processed until all addresses are consistent.*

Covering Your Eligible Dependents

If you elect coverage for yourself, you may also elect coverage for your family members who are "eligible dependents."

Covering Your Spouse or Domestic Partner

To elect coverage for your spouse or domestic partner, you must submit this documentation to establish eligibility to the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center). If you and your spouse or domestic partner work at LADWP and are eligible for health care coverage, you must each elect coverage; LADWP employees cannot be enrolled as the dependent of another LADWP employee.

Dependent Type	Documents Required for Verifying Eligibility
Spouse	> Social Security number > A copy of temporary marriage certificate > A copy of certified marriage certificate
Registered domestic partner[1]	> Social Security number > Your Declaration of Domestic Partnership issued by the California Secretary of State, or > An equivalent document issued by: — A local California agency, — Another state, or — A local agency within another state
Nonregistered domestic partner[1]	> Social Security number > Copies of you and your domestic partner's California driver's licenses or identification cards that show you share the same address and that it matches your address of record with LADWP, or other acceptable written verification showing that you and your domestic partner have been living at the same address for the last 12 months (proof that shows you are both receiving service and live at the residence, i.e. utility bill or financial document, such as a bank statement).[2] > The Affidavit of Domestic Partnership – Health and Dental Enrollment form[3] that provides proof that you and your domestic partner meet LADWP's required criteria, including: — Neither of you was married, in another domestic partnership or covered a spouse or domestic partner during the previous 12 months — You have lived together for the previous 12 months — You are both at least 18 years old — You and your domestic partner are not related by blood closer than would bar marriage in the state of California

[1] *For domestic partner coverage for Health Plan of Nevada, you must complete a Domestic Partner Rider form.*
[2] *Utility bills accepted include water, power and gas. Cable, internet, and phone are not accepted.*
[3] *The Affidavit of Domestic Partnership – Health and Dental Enrollment form authorizes your domestic partner to receive your health care benefits only.*