DOMESTIC PARTNERSHIP
HEALTH & WELFARE BENEFITS ELIGIBILITY

LBCC has expanded the Health and Welfare insurance coverage for active employees to include domestic partner eligibility. The term domestic partner refers to individuals as defined in the required, notarized Affidavit of Domestic Partnership.

Eligibility
To be eligible for coverage, the domestic partner must be your "sole spousal equivalent". You must both be adults and live together in an exclusive, committed relationship and assume joint responsibility for your basic living expenses. You must share a common residence and intend to continue to do so indefinitely. Your domestic partner must be at

Other Legal Consequences

Employees electing this benefit are advised to consult an attorney regarding the possibility that the filing of the Affidavit of Domestic Partnership may have other legal consequences, including the fact that it may, in the event of termination of the spousal equivalent relationship, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purpose of establishing and dividing community property, or for ordering payment of support.

When Coverage Ends

Coverage for your domestic partner will end if:

- Your domestic partner dies; or
- The criteria for an eligible domestic partnership as defined above are no longer met.

You must notify the Long Beach Community College Payroll/Benefits Office within 31 days after either of these events. You can file a Statement of Dissolution at any time you wish to terminate coverage of your domestic partner.

You cannot file another Affidavit of Domestic Partnership for a new domestic partner until at least 6 months after you file a Statement of Dissolution. There is no waiting period required for filing a second Affidavit of Domestic Partnership for a domestic partner for whom you previously filed a Statement of Dissolution, but you must wait until the next available open enrollment period to add them back to the plans.

Benefits for eligible domestic partners apply to medical (including mental health), dental and vision coverage.

Enrollment Instructions

1. Complete, sign and notarize the enclosed Affidavit of Domestic Partnership.

2. Attach a copy of proof of shared financial obligations with proper documentation (e.g., joint mortgage or lease, utility statement joint ownership of vehicle, joint checking/credit account).

3. Complete the enclosed Domestic Partner Health Care Enrollment Statement and submit it along with the carrier enrollment forms to the Benefits Office at LAC T-1026. Carrier enrollment forms are available online at https://www.lbcc.edu/pod/benefits-forms-documents
For further assistance, contact the Benefits Technician at (562) 938-4531.

DOMESTIC PARTNER HEALTH CARE ENROLLMENT STATEMENT

To enroll_____ in the Long Beach Community
(Name of Domestic Partner)
College District healthcare plans as the Domestic Partner of _____,
(Nameof Employee)

I declare and acknowledge my understanding that:

- x All group health care coverage is governed by the terms of the underlying plan(s).
- x I have submitted the Affidavit of Domestic Partnership establishing that my domestic partner and I reside together and are financially interdependent.
- x The District has no legal obligation to extend COBRA benefits to my domestic partner.
- x I understand that the Internal Revenue Service currently treats as imputed income to the employee the value of the health care coverage provided to domestic partners.
- x I have an obligation to file a Statement of Dissolution with the District within 31 days of the death of my domestic partner or the date the criteria of a domestic partner relationship listed in the Affidavit of Domestic Partnership are no longer met by me and my domestic partner.
- x

submitted the Election Form required for coverage under the desired
lying plan(s), and request the cover

Date Employee's Signature

_____ Address

_____

City State Zip

Affidavit of Domestic Partnership

Section One

I, _____and

to which we agree to be bound. We acknowledge that, depending on the health care plan we select the applicable Group Agreement may include, for example and without limitation, (1) a requirement that each of us arbitrate any and all claims, including malpractice claims, against the health care plan we choose and its related organizations and providers; and (2) the right of the health care plan to terminate coverage on the grounds set forth in the Group Agreement including, without limitation,

STATEMENT OF DISSOLUTION OF DOMESTIC PARTNERSHIP

I, _____, affirm under penalty of perjury, that:
Name of Employee (print)

1. I, _____, and_____
Name of Employee (print) Name of Domestic Partner (print)
no longer reside together nor share the common necessities of life.

2. I affirm that the effective date of the dissolution of the domestic partnership is _____

3. I affirm that the effective date of the dissolution statement has been mailed to the other partner.

4. I understand that another Affidavit of Domestic Partnership cannot be filed until six (6) months from the date of filing this Statement of Dissolution.

_____ _____
Date Signature of Employee