



DOMESTIC PARTNERSHIP BENEFITS REQUEST FORM

<input type="checkbox"/> REGISTRATION	<input type="checkbox"/> AMENDMENT	<input type="checkbox"/> TERMINATION
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PART I – REQUESTING EMPLOYEE INFORMATION	
Name (Last, First, Middle Initial)	Employee Number
Employee Home Address	City/State/Zip Code
Job Title	Department
Home Number	Status: FT/PT/Temp.

PART II – DOMESTIC PARTNER INFORMATION	
Name of Domestic Partner	
Home Address	City/State/Zip Code
EMPLOYEE ELIGIBILITY	
Documentation Required (Check One):	
<input type="checkbox"/> Domestic Partner Certificate	<input type="checkbox"/> Marriage Certificate
<input type="checkbox"/> Proof of Civil Union/Domestic Partnership issued by other Jurisdiction	<input type="checkbox"/> Other (Please Specify): _____
Employee must submit proof of eligibility <u>with</u> this form.	

PART III – BENEFIT ELECTION	
Please check the selection that applies (attach appropriate request for leave form if applicable):	
<input type="checkbox"/> Sick Leave	<input type="checkbox"/> Family/Medical Leave
<input type="checkbox"/> Bereavement Leave	<input type="checkbox"/> Medical Insurance
<input type="checkbox"/> Other (Please Specify): _____	

PART IV - AFFIRMATIONS	
I certify that the information provided in all parts of this form is true, accurate and complete.	
_____ Employee Signature	_____ Date

PART VI - APPROVAL	
_____ Human Resources Director/Designee	
_____ Date	