

6. EMPLOYEE INFORMATION

Name: _____
Last Name First Name MI

Street Address: _____

City _____ State _____ Zip Code _____

Social Security # ____ - ____ - ____ Date of Birth: ____/____/____ Gender: M or F

7. DOMESTIC PARTNER INFORMATION

Name: _____
Last Name First Name MI

Street Address: _____

City _____ State _____ Zip Code _____

Social Security # ____ - ____ - ____ Date of Birth ____/____/____ Gender: M or F

Partnership began on _____

8. DOMESTIC PARTNER DEPENDENT CHILD INFORMATION

(List only the domestic partner’s unmarried biological or adopted child(ren) who are in the custody and care of the domestic partner and a member of the employee’s household.)

Name of Dependent Child	Social Security Number	Date of Birth	Full-time Student (Yes/No)

III. NOTOFICATION OF CHANGE IN OR TERMINATION OF DOMESTIC PARTNERSHIP

We agree that, if this domestic partnership is terminated, we will notify HACC within thirty-one (31) days of such termination or change by contacting Human Resources.

III. ACKNOWLEDGEMENTS

- A. We understand that the information provided in this statement will be treated as confidential but will be subject to disclosure:
 - 1. upon the express written authorization of the undersigned employee OR
 - 2. if otherwise required by law.

- B. We understand that this statement may have implication to the taxability of benefits provided. We understand that before signing this statement we should seek tax advice concerning such matters. We acknowledge that HACC has provided us with no advice in this regard.

- C. We affirm that the assertions made herein are true and correct to the best of our knowledge.

Employee Signature

Employee Printed Name

Date

Employee Social Security Number

Domestic Partner Signature

Domestic Partner Printed Name

Date