

ST. MARY'S COLLEGE OF MARYLAND

State of Maryland Same-Sex Domestic Partner Health Benefits Policy

In recognition of committed relationships of same-sex domestic partners and as described below, the State of Maryland offers health benefits to employees occupying permanent ongoing positions and their same-sex domestic partners. The intent of this policy is to offer the same benefits to employees and their domestic partners that are offered to employees and their married spouses.

The State of Maryland defines same-sex domestic partners as an individual in a relationship with an employee who is the same sex as the employee, if both individuals: are at least 18 years old; are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule; are not married, in a civil union, or in a domestic partnership with another individual; have been in a committed relationship of mutual interdependence for at least 12 consecutive months in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and share a common primary residence. The employee and same-sex domestic partner must complete an affidavit affirming the authenticity of the domestic partnership relationship.

A. Medical

Domestic partners of State employees are eligible for participation in the State of Maryland health insurance plans. An employee whose same-sex domestic partner relationship has been verified utilizing eligibility criteria mandated by the State of Maryland shall be eligible to participate.

Documentation of a domestic partner relationship and of enrollment of the domestic partner in a health and/or prescription insurance plan must be submitted to the Office of Human Resources for review. Employees are responsible for notifying the Office of Human Resources within sixty (60) days of the dissolution of a registered domestic partner relationship.

Employees who elect to participate in this benefit should note income tax implications of participation. Domestic partner benefits paid by the State of Maryland may be considered federal and State income to the College employee by the Internal Revenue Service (IRS) and the State.

Employees assume all responsibility for any tax implications that result from participation in this program.

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B. Leave: Sick, Bereavement, and Parental

Sick leave.

Employees who have a same-sex domestic partner registered with the Office of Human Resources may use their accrued sick leave for the illness of the employee's domestic partner and the domestic partner's parents. Documentation of the illness and need for the employee's presence must be submitted to the Office of Human Resources upon the employee's return to work.

Bereavement leave.

A maximum of three (3) working days may be used by an employee for bereavement leave in the event of the death of the employee's domestic partner, domestic partner's child, sibling of the domestic partner, or parent of the domestic partner. The leave will be charged to an employee's sick leave balance. If overnight travel is required due to the death of one of these family members, a maximum of five (5) working days may be charged to sick leave.

Parental leave.

Six weeks (30 days) of parental leave shall be provided to an employee who occupies a permanent full-time position for the purposes of birth and/or introduction of a child into the employee's home (including adoption or placement prior to adoption). The Office of Human Resources must receive the parental leave request forms prior to the birth or placement of the child.

Any employee (male or female) who has been employed by the College for a period of at least one year in a permanent full-time position shall be provided with thirty (30) days of paid leave for child/ren born or placed in the employee's home. If both parents (or primary care givers) are employed by the College, a maximum of thirty (30) days shall be shared. The birth or placement of the child must occur after one year of full-time employment in a permanent position. Parental leave shall commence on the first day's absence from work. The use of Parental Leave shall not be charged against the employee's accumulated leave balances. The thirty (30) days may be used as requested by the employee after consideration and approval of the request by the supervisor. Requests to use the leave intermittently shall be accompanied by a written schedule of the intended leave schedule.

The intermittent leave schedule must be approved by the supervisor and submitted to the Office of Human Resources.

Employees are eligible for this parental leave benefit once every three years.

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C. Tuition Waiver

Same-sex domestic partners of employees who occupy permanent full-time positions are entitled to the same tuition waiver benefits offered to married spouses of St. Mary's College of Maryland employees. All provisions and exclusions of the applicable policy apply. An employee may be subject to income tax for tuition waiver benefits granted to the employee's domestic partner.

D. Other Benefits.

Same-sex domestic partners of full-time College employees shall have access to the physical facilities of the College and shall receive the same discount for all College events and productions as offered to married spouses of full-time College employees.

State of Maryland Same-Sex Domestic Partner Health Benefits Procedures

1. Full-time employees occupying permanent positions must register qualified same-sex domestic partners with the Office of Human Resources prior to receiving benefits. In order to be eligible, the employee and domestic partner must:
 - a. be of the same sex;
 - b. provide the domestic partner's full legal name, permanent address, and social security number to the College;
 - c. share financial and other resources for mutual benefit and responsibility;
 - d. have lived together for at least the last twelve (12) months;
 - e. be at least eighteen (18) years old;
 - f. have voluntarily consented to the relationship, without fraud or duress;
 - g. not be married to, in a civil union, or in a domestic partner relationship with another individual;
 - h. not be related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
 - i. be legally competent to contract;
 - j. share joint title to real estate, a joint housing lease, or a joint mortgage, and provide evidence of at least three (3) of the following items:
 - i. joint ownership of a motor vehicle; or a joint real estate holding – such as a mortgage or a joint housing lease.
 - ii. a joint banking account; or a joint credit account; or a joint debt or loan account;
 - iii. designation of the partner as a beneficiary of the employee's life insurance, retirement benefits, or residuary estate under a will;

- iv. designation of the partner as holding a power of attorney for financial and legal decisions regarding the employee; and
 - v. designation of the partner as holding a durable power of attorney for health care decisions regarding the employee;
 - k. sign a legal affidavit as to the authenticity of the relationship
- 2. Documentation for eligibility of same-sex domestic partner benefits must be furnished upon registration (see letter “j” above or St. Mary’s College of Maryland Same-Sex Domestic Partner Policy for acceptable documentation).
- 3. Dissolution of a domestic partner relationship must be reported to the Office of Human Resources within sixty (60) days of dissolution. The domestic partner will be removed from eligibility for benefits on the first day of the next calendar month.

Affidavit for Domestic Partnership and Domestic Partner's Dependents

This Affidavit must be completed if you are adding coverage for a Domestic Partner or Dependent Child of a Domestic Partner

Domestic Partnership:

I, _____ and _____,
(Employee/Retiree) (Domestic Partner)

certify that we are Domestic Partners (as defined in the benefits guide) and that we:

- (1) Are each at least 18 years old;
- (2) Are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
- (3) Are not married, in a civil union, or in a domestic partnership with another individual;
- (4) Have been in a committed relationship of mutual interdependence for at least **12 consecutive months** in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely;

Financial Interdependence is established by providing one of following dated documents:

- (a) Joint ownership or lease of a motor vehicle
 - (b) Joint lease, mortgage or deed of your primary residence
 - (c) Joint checking, savings, investment, or credit account
 - (d) Designation as the primary beneficiary for life insurance, retirement benefits or the domestic partner's will
 - (e) Mutual assignments of valid durable powers of attorney under Estates and Trusts Article, §13-601, Annotated Code of Maryland
 - (f) Mutual valid written advanced directives under Health-General Article, §5-601 et seq., Annotated Code of Maryland, approving the domestic partner as health care agent.
- (5) Share our common primary residence.

Common Primary Residence is established by providing one of the following documents:

- (a) Joint lease, mortgage or deed of your primary residence
- (b) Copies of individuals' driver's license, State-issued identification card or voter's registration card listing common primary address
- (c) Utility or other household bill with both the name of the insured and the domestic partner appearing.

Tax Affidavit for Domestic Partner:

In some cases, your Domestic Partner may qualify as an eligible tax dependent. If he/she meets **all** three criteria below, the coverage attributable to your domestic partner may be eligible for tax-favored treatment. Please **initial** each description that applies to your Domestic Partner only if all three apply **AND** include a copy of your most recent income tax filing (with salary information blacked out).

Initials	Tax Dependent Criteria:
	The Dependent is a person who is not my lawful spouse who lives with me and is a member of my household for the entire year.
	I provide over half of the Dependent's support for the calendar year(s) in which coverage is provided.
	The Dependent is not my or anyone else's qualifying child for the tax year(s) in which coverage is provided.

We solemnly affirm under the penalties of perjury under applicable state laws, that the foregoing is true and accurate. We understand that willful falsification of information contained in this Affidavit can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the domestic partner, and the termination of coverage for the employee/retiree. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees, because of a false statement contained in this affidavit. In addition, where permissible, employment related action may be taken against an active employee.

We agree to promptly notify the Department of Budget and Management, Employee Benefits Division upon any changes or circumstances attested to in this affidavit. We understand that we may not file another affidavit until at least one (1) year after termination of this domestic partnership.

Signature of Employee/Retiree	Social Security Number	Date
Signature of Domestic Partner	Social Security Number	Date

Dependent Tax Affidavit for Domestic Partner's Dependents:

Name of Employee/Retiree: _____ Social Security Number: _____

Name of Domestic Partner's Dependent: _____

Dependent's Date of Birth: _____ Social Security Number: _____

Part A: Dependent Relationship, Marital Status, and Age/Capability Requirements

A. Initial the box for the correct dependent relationship for your domestic partner's dependent listed above. If none apply, this person is NOT eligible to be added to your health benefits coverage.		
Initials	Dependent Relationship	Required Documentation
	Biological Child of Domestic Partner	- Copy of Child's Official State Birth Certificate
	Adopted Child or child placed with domestic partner for adoption by the Domestic Partner	- Copy of Adoption papers indicating child's date of birth - For pending adoptions – see Benefits Guide
	Step-Child of Domestic Partner	- Copy of Child's Official State Birth Certificate - Copy of domestic partner's Official State Marriage Certificate from previous marriage
	Grandchild of Domestic Partner	- Copy of Child's Official State Birth Certificate - Copy of Child's Parent's Official State Birth Certificate (to show relationship to domestic partner)
	Legal Ward of Domestic Partner (permanently resides with my domestic partner and my domestic partner is his/her testamentary or court appointed guardian for a non-temporary guardianship of not less than 12 months.)	- Copy of Child's Official State Birth Certificate - Proof of Residency (Valid Driver's License, or State-issued Identification Card, school records or day care records certifying dependent's address, Tax Documents listing child's name certifying address.) - Copy of Legal Ward/Testamentary Court Document, signed by a Judge.
	Other Child Relative (includes step-grandchildren) of Domestic Partner - dependent is related to my domestic partner by blood, permanently resides with my domestic partner, and my domestic partner provides his/her sole support.	- Copy of Child's Official State Birth Certificate - Proof of Residency (Valid Driver's License, or State-issued Identification Card, school records or day care records certifying dependent's address, Tax Documents listing child's name certifying address.) - Signature of Sole Support Affirmation (see below)
B. Initial the box below, if the Dependent is NOT married. If this person is married, he/she is NOT eligible for State employee/retiree health benefits coverage.		
	The Dependent is NOT married	
C. Initial the box by the statement that describes the Dependent. If neither statement accurately describes this Dependent, this person is not eligible for State employee/retiree health benefits coverage.		
	The Dependent is under the age of 25.	
	The Dependent is any age and is incapable of self-support because of a mental or physical incapability incurred before reaching age 25 and is chiefly dependent on me and/or my domestic partner for support.	

Sole Support Affirmation for Other Child Relative Dependent ONLY:

I certify by my signature below that the dependent child listed on this form is supported solely by me and/or my domestic partner.

Domestic Partner's Signature

Date

Part B: Tax Criteria:

In some cases, the dependent of your Domestic Partner may qualify as your eligible tax dependent. If he/she meets **all four** criteria for the Qualifying Child Test or **all three** criteria for the Qualifying Relative Test on the following page the coverage attributable to your domestic partner's dependent may be eligible for tax-favored treatment. **If you cannot initial all four Qualifying Child or all three Qualifying Relative criteria, this person is NOT an eligible tax dependent and the portion of your coverage attributable to this dependent is not eligible for tax-favored status.**

Initials	Qualifying Child Test Criteria – must meet all four criteria
	The child is my biological child or adopted child (or placed for adoption by me), my legal ward or child placed with me under court order (not temporary for less than 12 months), sibling, or descendent of my child or sibling (i.e. grandchild, niece, nephew, etc); and
	The child lives with me for more than half of the year (more than six months) or is my biological or adopted child and meets the following residence exceptions: <ul style="list-style-type: none"> - The child received over half of the child's support during the calendar year from the child's parents, who (1) are divorced or legally separated under a decree of divorce or separate maintenance, or (2) are separated under a written separation agreement, or (3) live apart at all times during the last six months of the calendar year; and - The child is in the custody of one or both of the child's parents for more than half of the calendar year; and -
	The Child (1) has not attained age 19 as of the close of the calendar year(s) in which coverage is provided, or (2) is a full-time student for at least five months of the calendar year who has not attained age 24 as of the end of the calendar year(s) in which coverage is provided, or (3) is permanently and totally disabled; and
	The child has not provided more than half of the child's own support for the calendar year(s) in which coverage is provided.

-OR-

Initials	Qualifying Relative Test Criteria – must meet all three criteria
	The Dependent has a specified relationship to me: my biological child, my adopted child (or placed for adoption by me), my step-child, my grandchild, my niece, my nephew, my sibling, or a person who is not my lawful spouse who lives with me and is a member of my household for the entire year (this includes a legal ward); and
	I provide over half of the Dependent's support for the calendar year(s) in which coverage is provided; and
	The Dependent is not my or anyone else's qualifying child for the tax year(s) in which coverage is provided. If this child meets criteria for the Qualifying Child Test, this statement is not true.

We solemnly affirm under the penalties of perjury under applicable state laws, that the foregoing is true and accurate. We understand that willful falsification of information contained in this Affidavit will result in our termination of enrollment. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees, because of a false statement contained in this affidavit.

Signature of Employee/Retiree

Date

Signature of Domestic Partner

Date

AFFIDAVIT OF DISSOLUTION OF DOMESTIC PARTNERSHIP

Employee Information

Employee Name (Last, First, Middle)			
Date of Birth	Gender (circle one) M F	Social Security Number	
Address		City	State Zip Code

Domestic Partner Information

Name (Last, First, Middle)			
Date of Birth	Gender (circle one) M F	Social Security Number	
Address		City	State Zip Code

Domestic Partner Dependent Child(ren) Information (List the domestic partner's unmarried biological or adopted child(ren) who are currently enrolled.

Dependent Child Name (Last, First, Middle)	Social Security Number	Date of Birth	RC*	Full-time Student Y / N

RC* (Relationship Code): **DS= biological or adopted son of domestic partner**
 DD=biological or adopted daughter of domestic partner

CERTIFICATION

This certifies that as of _____ (date) my domestic partnership with the above person has terminated. I understand that to register another domestic partnership and enroll that partner in State of Maryland sponsored benefits I must wait 12 months from the date listed above.

I further understand that the domestic partner's eligibility for the State of Maryland sponsored benefits ends on the date the domestic partnership terminates. Failure to notify the State of Maryland within 60 days of the termination date may result in my responsibility to refund the State for benefits paid for ineligible individuals. Continuation coverage similar to COBRA may be elected by the partner and/or the domestic partners covered children within 60 days of the termination of the domestic partner's health care coverage.

At least one of the following documents* must be attached to this affidavit as proof of the dissolution of the domestic partnership:

- Copy of lease or deed for either the Employee's/Retiree's or former domestic partner's new residence that does not list the domestic partner or Employee/Retiree as co-tenant or co-owner;
- Copy of change of address card for driver's license for either the Employee's/Retiree's or former domestic partner;
- Documents establishing the termination of joint ownership of assets/vehicles/investments that had been used to establish financial interdependence; or
- New designation of beneficiary under a life insurance policy, retirement benefits, will or power of attorney that removes the domestic partner.

* Other documents may be accepted. Contact the Employee Benefits Division for more information.

I solemnly affirm under the penalties of perjury under applicable state laws, that the foregoing is true and accurate. I understand that willful falsification of information contained in this Affidavit can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the domestic partner, and the termination of coverage for the employee/retiree. I understand that a civil action may be brought against me for any losses, including reasonable attorney fees, because of a false statement contained in this affidavit. In addition, where permissible, employment related action may be taken against an active employee.

Employee Signature _____ Date _____