ROCHESTER INSTITUTE OF TECHNOLOGY
Application for Domestic Partnership Benefits

In order to cover your Domestic Partner under RIT's benefits, you and your Domestic Partner must also complete the Affidavit of Domestic Partnership. If you covering your Domestic Partner under your medical, dental, and/or vision plan, you must also complete a Health Care Enrollment/Change Form.

Please complete each section of this four page form.

Name: ___________________________________ **Employee #:** _______________________

Medical Plan (complete 1 or 2 or 3)

1. ☐ **I wish to enroll** ☐ my domestic partner
   ☐ my domestic partner's dependent child(ren)

   under my medical policy as follows and I have attached a medical application form:
   - ☐ Blue Cross Blue Shield Comprehensive
   - ☐ Blue Point2 POS A
   - ☐ Blue Point2 POS B
   - ☐ Blue Point2 POS B No Drug
   - ☐ Blue PPO

   please indicate which coverage level you would have elected if you were not covering this person(s):
   - ☐ Individual
   - ☐ Family
   - ☐ Two Person
   - ☐ One Parent Family

   please indicate which coverage level you are electing:
   - ☐ Individual
   - ☐ Family
   - ☐ Two Person

   The person(s) I wish to enroll qualifies as my tax dependent(s) under the Internal Revenue Code as follows:

   Domestic Partner: ☐ yes ☐ no ☐ not applicable
   Child(ren) of Domestic Partner: ☐ yes ☐ no ☐ not applicable

   *I am making this enrollment/change due to (*mid-year changes must be made within 31 days of event):*
   - ☐ New Hire
   - ☐ Open Enrollment
   - ☐ *Change in status of ____ on _____________
     (enter event - e.g., domestic partner lost employment) *(enter date)*
   - ☐ *Completed 12 months of relationship on _____________

2. ☐ **I do not wish to enroll** my domestic partner and my domestic partner's dependent child(ren) under my medical policy at this time. I understand that I can only add my domestic partner and/or my domestic partner's dependent child(ren) to my medical policy during the annual Open Enrollment (held each Fall for a January 1 effective date) unless there has been a change in status (e.g., domestic partner loses employment). If there is a change in status, I understand that I must notify the Human Resources Department **within 31 days of the event** in order to add an individual(s) to my policy.

3. ☐ **I do not participate** in RIT's Medical Plan.

Vision Care Plan (complete 1 or 2 or 3)

1. ☐ **I wish to enroll** ☐ my domestic partner
☐ my domestic partner's dependent child(ren)

under my vision care plan and I have attached a vision care application form.

please indicate which coverage level you would have elected if you were not covering this person(s):
☐ Individual ☐ Two Person
☐ Family

please indicate which coverage level you are electing:
☐ Individual ☐ Two Person
☐ Family

The person(s) I wish to enroll qualifies as my tax dependent(s) under the Internal Revenue Code as follows:
Domestic Partner: ☐ yes ☐ no ☐ not applicable
Child(ren) of Domestic Partner: ☐ yes ☐ no ☐ not applicable

*I am making this enrollment/change due to (*mid-year changes must be made within 31 days of event):*
☐ New Hire
☐ Open Enrollment
☐ *Change in status of ____ on _____________
(enter event - e.g., domestic partner lost employment) *(enter date)*
☐ *Completed 12 months of relationship on _____________

2. ☐ **I do not wish to enroll** my domestic partner and my domestic partner's dependent child(ren) under my vision care policy at this time. I understand that I can only add my domestic partner and/or my domestic partner's dependent child(ren) to my vision care policy during the annual Open Enrollment (held each Fall for a January 1 effective date) unless there has been a change in status (e.g., domestic partner loses employment). If there is a change in status, I understand that I must notify the Human Resources Department **within 31 days of the event** in order to add an individual(s) to my policy.

3. ☐ **I do not participate** in RIT's Dental Vision Care Plan.

Dental Plan (complete 1 or 2 or 3)

2. ☐ **I wish to enroll** ☐ my domestic partner
☐ my domestic partner's dependent child(ren)

under my dental plan and I have attached a dental application form.

please indicate which coverage level you would have elected if you were not covering this person(s):
☐ Individual ☐ Two Person
☐ Family

please indicate which coverage level you are electing:
☐ Individual ☐ Two Person
☐ Family

The person(s) I wish to enroll qualifies as my tax dependent(s) under the Internal Revenue Code as follows:
Domestic Partner: ☐ yes ☐ no ☐ not applicable
Child(ren) of Domestic Partner: ☐ yes ☐ no ☐ not applicable

*I am making this enrollment/change due to (*mid-year changes must be made within 31 days of event):*
☐ New Hire
☐ Open Enrollment
☐ *Change in status of ____ on _____________
(enter event - e.g., domestic partner lost employment) *(enter date)*

☐ *Completed 12 months of relationship on _____________

4. ☐ **I do not wish to enroll** my domestic partner and my domestic partner's dependent child(ren) under my dental policy at this time. I understand that I can only add my domestic partner and/or my domestic partner's dependent child(ren) to my dental policy during the annual Open Enrollment (held each Fall for a January 1 effective date) unless there has been a change in status (e.g., domestic partner loses employment). If there is a change in status, I understand that I must notify the Human Resources Department **within 31 days of the event** in order to add an individual(s) to my policy.

5. ☐ **I do not participate** in RIT's Dental Plan.

Tuition Waiver (complete 1 or 2)

1. ☐ **I wish to enroll** ☐ my domestic partner
   ☐ my domestic partner's child(ren)

   in the Tuition Waiver Benefit and I have attached a Tuition Waiver form.

   The person(s) I wish to enroll qualifies as my tax dependent(s) under the Internal Revenue Code as follows:

   Domestic Partner: ☐ yes ☐ no ☐ not applicable
   Child(ren) of Domestic Partner: ☐ yes ☐ no ☐ not applicable

2. ☐ **I do not wish to enroll** my domestic partner and my domestic partner's child(ren) under my tuition waiver benefit at this time. I understand I can enroll them in the future by completing the necessary forms.

Tuition Exchange (complete 1 or 2)

1. ☐ **I wish to enroll** ☐ my domestic partner's child(ren)

   in the Tuition Exchange Benefit.

   The person(s) I wish to enroll qualifies as my tax dependent(s) under the Internal Revenue Code as follows:

   Child(ren) of Domestic Partner: ☐ yes ☐ no

2. ☐ **I do not wish to enroll** my domestic partner's child(ren) under my tuition exchange benefit at this time. I understand I can enroll him/her in the future by completing the necessary forms.

Additional Information and Signature Section

By signing this application I, the undersigned employee, understand that:

1. Domestic partners and their dependents are subject to the same plan guidelines which govern all other participants in RIT's benefit programs to the extent possible. The plan documents and the insurance contracts govern all questions of coverage.
2. RIT reserves the right to request proof that the domestic partnership meets the eligibility criteria set forth in the Domestic partners Benefits Policy and I agree to provide RIT with supporting documents (e.g., a domestic partner agreement, an affidavit of domestic partnership, the existence of joint bank accounts, joint liability for mortgages and the like) if requested to do so. RIT in its sole discretion has the right to determine whether the criteria have been satisfied.
3. Although RIT's present intention is to offer medical care, dental and/or vision care continuation coverage to domestic partners and their dependent children through COBRA, it has no legal obligation to do so, and, as with all health insurance coverage, is dependent on the insurance carrier's guidelines.
4. Unless I can claim my domestic partner and his/her dependent children as my dependents on my tax return, I understand the Internal Revenue Service currently treats as imputed income to me the value of the medical and/or dental coverage provided to my domestic partner and his/her dependent children, if any, minus any contribution paid by me for this coverage. I further understand that the employee contribution for the additional coverage for my domestic partner and his/her dependent children will be paid with after-tax dollars.
5. I understand that the Internal Revenue Service treats as taxable income to me the value of any Tuition Waiver and/or Tuition Exchange benefits provided for my domestic partner and/or my domestic partner's child(ren) and that I am responsible for paying these taxes to RIT who will in turn remit these taxes to the appropriate government agency.
6. If there is any change in our status as domestic partners as certified in this application, I will notify RIT within thirty-one (31) days of such a change. If this change results in a termination of the domestic partnership status, a *Statement of Termination of Domestic Partnership* must be completed and filed with the Human Resources Department. The domestic partnership status will be terminated as of the date indicated on the Statement of Termination.
7. I understand that RIT may change its rules on domestic partners, on COBRA benefits, and any other aspect of the affected benefit plans at any time.

I affirm the statements made above are true and complete to the best of my knowledge and understand that false statements and/or the failure to notify RIT of any change in status can result in termination of employment.

______________________________ ____________________

Employee Signature Date