DOMESTIC PARTNER BENEFIT INFORMATION

Thank you for your interest in offering Domestic Partner Benefits through the CAMPS Health Trust.

These benefits are available through the CAMPS Health Trust on a group-by-group basis. Those companies that meet the following criteria may offer their company benefits to Domestic Partners of their employees:

(1) The company must have adopted its own internal policy defining Domestic Partnership. A copy of the policy must be filed with EPK & Associates.
(2) Those individuals (and their Domestic Partner) requesting Domestic Partner benefits must complete and file with EPK & Associates an "Affidavit of Domestic Partnership" in a form previously approved by the CAMPS Health Trust.
(3) Individuals requesting Domestic Partner benefits may be brought on the company plan at the following times;
    (a) Within 30 days of the date the company's internal Domestic Partner policy is adopted;
    (b) At Open Enrollment;
    (c) Within 30 days of any HIPAA qualifying event.

This information is provided as a general overview of the requirements necessary to offer Domestic Partner benefits through the CAMPS Health Trust. If you have further questions or need additional information please contact EPK & Associates at the address and telephone number below.

Affidavit of Domestic Partnership

Section I.

We, _____ and _____
(Print Employee's Name) (Print Domestic Partner's Name)
hereby declare, under penalty of perjury, that we became domestic partners on _____(date) in accordance with the following criteria:

1. We currently share the same regular permanent residence; and
2. We have a close personal relationship; and
3. We are jointly responsible for "basic living expenses" as defined below; and
4. We are not married to anyone; and
5. We are each eighteen (18) years of age or older; and
6. We are not related by blood closer than would bar marriage in our state of residence; and
7. We were mentally competent to consent to contract when our domestic partner partnership began; and
8. We are each other's sole domestic partner and are responsible for each other's common welfare.

"Basic living expenses" means the cost of basic food, shelter, and any other expenses of a Domestic Partner. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

Section II.

I understand that this Affidavit shall be terminated upon the death of my domestic partner or by change of circumstance attested to in this Affidavit.

I agree to notify the CAMPS Trust Administrator, EPK & Associates, Inc., if there is any change of circumstances attested to in this Affidavit within 30 days of change by filing a *Statement of Termination of Domestic Partnership*.

- Over Please -

Section III.

We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or if otherwise required by law.

We understand that this declaration of responsibility for our common welfare may have legal implications under our State law.

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 of Domestic Partnership.

We also certify under penalty of perjury, under our State laws, that the foregoing is true and correct.

_____	_____
(Employee Signature)	(Signature of Domestic Partner)
_____	_____
(Print Employee Name)	(Print Domestic Partner Name)
_____	_____
_____	_____
(Address)	(Address)
_____	_____
(Date)	(Date)

_____
(Employer Name)

_____
(Employer Group Number)

Statement of Termination of Domestic Partnership

This statement is intended for the sole purpose of determining eligibility for Domestic Partnership with my employer. When this statement is received by the CAMPS Trust Administrator, EPK & Associates, Inc., benefits will be discontinued on the last day of the month in which the statement is received.

I, _____ certify the following is accurate:
(Print Employee Name)

_____ and I are no longer domestic partners as defined in the
(Print Domestic Partners Name)

Affidavit of Domestic Partnership filed by me with my employer on _____.
(Date)

I am filing the Statement of Termination in order to cancel the previously filed Affidavit of Domestic Partnership.

On _____ I will mail my former domestic partner a copy of the notice at:
(Date)

_____

_____
(Address Notice Will Be Sent To)

I declare the above statement to be true and correct.

_____ _____
(Employee Signature) (Date)

INTERNAL USE ONLY:

I acknowledge the receipt of the Statement of Termination:

_____ _____
(Signature of Employer Representative) (Date)

_____ _____
(Employer Name) (Employer Group Number)