ILWU-PMA WELFARE PLAN • 1188 FRANKLIN ST., SUITE 300 • SAN FRANCISCO, CA 94109 • (415) 673-8500

SAME SEX DOMESTIC PARTNER CERTIFICATION FORM

This form must be notarized and returned to the Benefit Plans Office.

Employee's name_____Local/Reg No.____ _____

Partner's Name _____Birthdate ____/____/_____

I confirm that the above named individual is my Same Sex Domestic Partner and that:

1) he or she is at least 18 years of age;
2) he or she shares a close personal relationship with me and we are responsible for each other's common welfare;
3) we are each other's sole domestic partner;
4) I am not married and have not had another domestic partner enrolled in the Plan within the prior 12 months;
5) we jointly share the same residence and are members of the same household, with the intent to continue doing so indefinitely; and
6) we are not related by blood closer than would bar marriage.

Provide a copy of at least two of the following as verification of the same sex domestic partner's common residency (dated to confirm eligibility at the time of enrollment): (i) driver's license, (ii) proof of auto insurance, (iii) State Identification Card, (iv) utility bill, or (v) voter registration.

CERTIFICATION: I certify that all information on this form is true and correct, and agree to provide any additional information the Trustees may request. ***I understand that if I misstate or misrepresent any information on this form, my dependents and I may each lose eligibility for benefits under the ILWU-PMA Welfare Plan.***

_____ _____

Date **Employee Signature**

State of _____ **NOTARIZATION REQUIRED**

County of _____

On_____, before me, _____, Notary Public,

personally appeared_____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument. I certify under PENALTY OF PERJURY under the laws of the State in which this was signed that the foregoing paragraph is true and correct.

Witness my hand and official seal.

_____ [seal]

Signature of Notary Public My commission expires_____ _____

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IMPORTANT NOTICE REGARDING TAXATION

If your otherwise eligible dependent child or same sex domestic partner does not qualify as a dependent under Section 152 of the Internal Revenue Code, the fair market value of the dependent coverage will be reported as taxable income and, if you are an active employee, income and payroll taxes on the fair market value of the dependent coverage will be withheld from your weekly paycheck. (For example, if you live in California, where the payroll tax rate is 16.1%, and if your income tax withholding is 15%, you will have a total of 31.1% of the fair market value of the dependent coverage withheld from your weekly paycheck.)

Participants are not required to pay payroll taxes on the value of dependent coverage for any dependent as long as the otherwise eligible dependent meets the following requirements:

For children who are your natural child, legally adopted child, step child, foster child or child under legal guardianship:

(1) is a citizen, resident, or national of the United States;
(2) resides with you for more than half the year (unless the parents are divorced and the non-custodial parent has a written agreement permitting him or her to claim the child as a dependent);
(3) does not provide more than half of his or her own support;
(4) is not claimed as a dependent by another taxpayer.

For children of a domestic partner or children who are NOT your natural child, legally adopted child, step child, foster child or child under legal guardianship:

(1) is a citizen, resident, or national of the United States;
(2) resides with you as a member of your household;
(3) receives the majority of his or her annual support (food, clothing, housing, and medical care) from you; and
(4) is not claimed by another taxpayer.

For same sex domestic partner:

(1) is a citizen, resident, or national of the United States;
(2) receives the majority of his or her annual support (food, clothing, housing, and medical care) from you; and
(3) lives with you as a member of your household.

Please use the form on the back of this notice to indicate whether the exemption criteria above are met for the dependent(s) you wish to add to your ILWU-PMA Welfare Plan coverage.

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IMPORTANT NOTICE REGARDING TAXATION

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Employee's name_____ Local / Reg No_____

Please list the dependents you are adding to your ILWU-PMA Welfare Plan coverage and indicate by checking "Yes" which dependents meet the exemption criteria listed on the front of this form. If they do not meet the criteria, check "No". If you mark "No" in this section, the dependent coverage will be reported as taxable income as described on the front of this form.

Dependent name:	Date of birth:	Yes	No
_____	__/__/__	____	____
_____	__/__/__	____	____
_____	__/__/__	____	____
_____	__/__/__	____	____
_____	__/__/__	____	____

DOCUMENTATION REQUIRED:

You will need to submit Worksheet 1, IRS Publication 501 for each dependent you marked "Yes" who is any of the following: (1) a same sex domestic partner, (2) a child that is your foster child, (3) a child that is under your legal guardianship, (4) a fulltime student at least 19 and under 23, (5) dependent child that is permanently and totally disabled, (6) a same sex domestic partner's child, (7) any child for whom you submit a notarized Dependent Child Certification Form.

CERTIFICATION: I certify that all information on this form is true and correct, and agree to provide any additional information the Trustees may request. ***I understand that if I misstate or misrepresent any information on this form, my dependents and I may each lose eligibility for benefits under the ILWU-PMA Welfare Plan.***

Employee Signature:_____ Date:_____