DECLARATION OF DOMESTIC PARTNERSHIP

We declare, under penalty or perjury, under the laws of the State of _____ that the assertions in this Declaration are true to the best of our knowledge. We understand that this form is not an application for health insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under the School of Visual Arts health insurance program.

Employee's Signature_____ Date_____

Social Security Number_____

Partner's Signature_____ Date_____

Social Security Number_____

Address of Employee & Partner_____

_____

_____

COUNTY OF)
) SS
STATE OF)

Subscribed and sworn to before me this _____ day of _____, 20___

_____
Notary Public

My Commission Expires: _____