HEALTH CARE ENROLLMENT STATEMENT

To enroll _____, and his or her eligible
(Name of Domestic Partner)

dependent children, if any, in the District's group health care coverage that, subject to certain limitations, covers District employees and their Domestic Partners, I declare and acknowledge my understanding that:

- The options under the group health coverage currently available to employees who choose to enroll their Domestic Partners may be more limited than those available to other employees (i.e., limited to medical coverage only).
- All group health coverage is governed by the terms of the underlying plan(s) ("Plan").
- The effective date of coverage may only coincide with the District's annual health care re-enrollment date next following the timely receipt of my signed election.
- The District has no legal obligation to extend COBRA benefits to the Domestic Partners, but District has decided to offer limited continuation coverage to the Domestic Partner.
- I understand that I should consult an attorney concerning the income tax implications of filing this Affidavit and that neither the District, the San Diego County Schools Voluntary Employees Benefits Association nor any employee or agent can definitely identify the tax consequences.
- I have an obligation to file a statement of Disenrollment, Death or Termination of Domestic Partnership with the District's Plan Administrator or designated representative within (30) days of the earliest of (a) the death of my Domestic Partner, or (b) the date on which any of the criteria of a Domestic Partner relationship is no longer met.
- Regardless of whether the requisite Statement of Disenrollment, Death or Termination of Domestic Partnership has been filed, the effective date of the end of the Domestic Partner relationship, and, therefore, the date on which coverage of my Domestic Partner and his or her dependent children, if any, will end, according to the terms of the Plan, is the earliest of:
  - The date on which my Domestic Partner dies;
  - The date on which my Domestic Partner and I are legally separated;
  - The date on which one or more of the criteria of Domestic Partnership are no longer met; or
  - The date on which I file a Statement of Disenrollment, Death, or Termination of Domestic Partner with the District's Plan Administrator or designated representative.

I affirm that the statements in this Statement are true to the best of my knowledge.

DATED:_____ _____
(Signature)

_____ _____
(Printed Name of Employee) (Address)