HEALTH CARE AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Kathy Slater Huff, Deputy Secretary
Niki Kozlowski, Acting Deputy Secretary
Alanna Dancis, Acting Medicaid Director

State of New Mexico
Health Care Authority

AFFIDAVIT OF DOMESTIC PARTNERSHIP

As required by Executive Order 2003-010, this affidavit must be used to apply for domestic partner benefits and must be filed with the state employee's human resources office.

A. DECLARATION OF DOMESTIC PARTNERSHIP

I,_____ , declare that I am in a domestic partnership with
(Print State Employee's Name)
_____. Further, we declare that:
(Print Domestic Partner's Name)

1. We are in an exclusive and committed relationship for the benefit of each other, and our relationship is the same as, or similar to, a marriage relationship in the State of New Mexico.
2. We share and have shared together for 12 or more consecutive months a common, primary residence.
3. We are jointly responsible for each other's common welfare and we share financial obligations.
4. Neither of us is married or a member of another domestic partnership; nor have either of us been so during the past 12 months.
5. We are both at least 18 years of age.
6. We are both legally competent to sign this Affidavit of Domestic Partnership.
7. We are not related by blood to a degree of closeness that would prevent us from being married to each other in the State of New Mexico.

B. BENEFITS FOR THE ELIGIBLE DEPENDENTS CHILDREN OF THE DOMESTIC PARTNER

Domestic partner benefits are also available to the domestic partner's children, provided, however, that the child is primarily dependent upon the employee or domestic partner for support and is an eligible dependent child because:

1. Either of the domestic partners is the biological parent of the child;
2. Either or both partners are adoptive parents of the child; or
3. The child has been placed in the Domestic Partners' household as part of an adoptive placement, legal guardianship, or by court order (excludes foster children).

We declare that the following named individual(s) is/are eligible dependent child(ren):

_____
(For each Eligible Dependent Child, list the child's name and describe the relationship to the Domestic Partner)

C. EXCLUSIONS

Except for the eligible individuals named in Section B above, the following persons are not covered by Domestic Partner benefits and are not considered eligible dependents: parents, foster children, mere roommates, and other relatives who are related to the state employee to such a degree of closeness that marriage would be prohibited in the State of New Mexico.

D. ACKNOWLEDGMENTS

1. By signing this Affidavit of Domestic Partnership, we agree to notify the human resources office at the state employee's job in writing within 31 days (a) of any change in our status as domestic partners when any of the items in the Declaration of Domestic Partnership (paragraph, A above) no longer apply, (b) because we wish to terminate our domestic partnership (termination notice must be done using the Health Care Authority form "Affidavit of Termination of Domestic Partnership"), or (c) in the event a dependent ceases to meet the eligibility requirements for benefit coverage.

2. We understand that the value of insurance benefits provided to the domestic partner is considered by the federal Internal Revenue Service as taxable income to the employee, that the value thereof is subject to social security and federal income tax withholding, and that current state tax laws require state income tax withholding as well.

3. We understand that the State of New Mexico will pay its portion of the premium on the domestic partner's and dependent benefits, if any, in the same proportion as is paid for similar benefit premium portions paid for spouses and dependents of married persons covered by the state employee's benefits program, and that the state employee is required to pay their portion of the premium on the domestic partner's and dependent benefits, if any, in the same proportion as is required for similar benefit premium portions that married state employees pay for spouses and dependents.

4. We acknowledge that we are hereby advised to seek competent legal advice about present and future financial obligations we may be undertaking before we sign this Affidavit of Domestic Partnership.

5. We understand that at any time we may be requested in writing by the Health Care Authority to provide reasonable written proof that we are jointly responsible for the common welfare of each other, that we share financial obligations, and/or to show that the named dependents, if any, are eligible for benefits coverage, and that if we fail to provide such requested proof, then the domestic partner or dependent benefits can be denied or terminated.

6. WE UNDERSTAND THAT ANY MISREPRESENTATION OF FACT MADE IN THIS AFFIDAVIT OF DOMESTIC PARTNERSHIP MAY RESULT IN LOSS OF BENEFITS AND/OR DISCIPLINARY ACTION, AND THAT AS A RESULT OF SUCH MISREPRESENTATION THE STATE EMPLOYEE MAY BE REQUIRED TO REIMBURSE THE STATE OF NEW MEXICO FOR ANY COST FOR PROVIDING BENEFIT COVERAGE OR FOR PROVIDING THE ACTUAL BENEFITS, SUCH COSTS INCLUDING, AMONG OTHER THINGS, ATTORNEY'S FEES.

E. NOTARIZATION

We affirm, under penalty of perjury, that the assertions in this Affidavit of Domestic Partnership are true and correct. *(<u>Both</u> partners must sign this legal document in the presence of a Notary Public.)*

Signature of State Employee	(Print State Employee's Name)
Signature of Domestic Partner	(Print Domestic Partner's Name)

Common Residence Address	City	State	Zip Code
Mailing Address	City	State	Zip Code

STATE OF NEW MEXICO)
)
s
s
.
COUNTY OF _____)
(County Name)

SUBSCRIBED AND SWORN to this _____ day of _____20_____ , by
_____, an employee of the State of New Mexico, and
(Print State Employee's Name)
_____, the State Employee's Domestic Partner.
(Print Domestic Partner's Name)

My Commission Expires:_____ _____
Notary Public

Para asistencia en español con este formulario, por favor llame a EASI GOV al 1-855-618-1800

Revised 09/30/2026