Domestic Partner Benefits Enrollment Form

Employee Information

Employee Name:

Employee ID:

Department:

Domestic Partner Information

Partner Name:

Date of Birth:

Social Security Number:

Benefit Selection

- [ ] Medical Insurance
- [ ] Dental Insurance
- [ ] Vision Insurance

Affirmation

By submitting this form, I affirm that the information provided is true and complete, and I understand I may be required to provide proof of domestic partnership.

Employee Signature:

Date:

Submit