UNIVERSITY OF LETHBRIDGE

Domestic Partner and Spousal Declaration

I, _____, being eligible to participate in the University of Lethbridge dental, extended health, optional life insurance, and accidental death and dismemberment plans do hereby declare that I have either legally married or have been in a conjugal relationship and have cohabited with:

_____ _____

(Name please print) (Male/Female)

for a minimum of 12 consecutive months immediately prior to this declaration. The date legally married or date of commencement of continuous cohabitation was on _____. This relationship is characterized by a community represented relationship in the community in which we reside.

NB Only one spouse/domestic partner will be eligible for insurance premiums under these insured benefits and the spouse/domestic partner noted above will be the eligible spouse/domestic partner until a subsequent declaration is made by the employee, or the employee and/or spouse/domestic partner no longer meet the definition. The University's obligation and responsibility is limited to payment of appropriate premiums.

This individual is the person I select to be covered as my spouse/domestic partner and replaces any other person designated as my spouse/domestic partner of the previous legal, or domestic partner relationship.

I warrant that the reasons given to substantiate this qualification are accurate, and I understand that no premium payment will be made under any benefit provision in respect of said spouse/domestic partner or dependent if, on the date of a claim, this person(s) does not at that time qualify as my spouse/domestic partner or dependent and that the University's obligation and responsibility is limited to payment of appropriate premiums, when available.

_____ _____

(Signature of Employee) (Signature of Witness)

_____ _____

(Date of Declaration) (Date of Witness Signature)

_____ _____

(Employee I.D. Number) (I.D. Number of Domestic Partner, if available)