CERTIFICATE OF DOMESTIC PARTNERSHIP

SECTION ONE — AFFIRMATION OF DOMESTIC PARTNERSHIP

We the undersigned, declare that we are domestic partners, and we:

1. Are each eighteen (18) years of age or older;
2. Share a close personal relationship and are responsible for each other's common welfare;
3. Are each other's sole domestic partner;
4. Are not legally married to anyone, nor have a valid State of Oregon Domestic Partner Agreement;
5. Are not related by blood closer than would bar marriage in the State of Oregon;
6. Jointly share the same regular and permanent residence with the intent to continue doing so indefinitely;
7. Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, medical expenses, and any other expenses of maintaining a household. (Domestic Partners need not contribute equally or jointly to the cost of these expenses as long as they agree that they are both responsible for the cost.)

SECTION TWO — DECLARATION OF MEMBER

1. I understand that my domestic partner is eligible for enrollment at:
   a. The time I become eligible for healthcare coverage following my date of hire;
   b. During an annual open enrollment period; or
   c. Within 31 days of meeting the criteria listen in Section One.
2. I understand that children of my domestic partner are eligible if they meet the requirements for an eligible dependent as defined by the CIS Employee Benefits Policy.
3. I understand that coverage for my domestic partner shall terminate upon a change in circum-stances attested to in Section One of this Certificate.
4. I agree to provide written notice to my employer representative if there is any change of circum-stances attested to in this Certificate within 31 days of the change by filing a "Statement of Termination of Domestic Partnership."
5. I understand that this Certificate will terminate upon the death of my domestic partner.

SECTION THREE DECLARATION OF PARTNERS

1. We understand that the information contained in the Certificate relates to eligibility for benefits under a group medical, dental, or life plan. We further understand that the information contained in the Certificate will be held confidential and will be subject to disclosure only upon the express written authorization or as required by law.

2. We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Certificate of Domestic Partnership.

3. We understand that under applicable federal and state income tax law, payments for health coverage of a domestic partner are not eligible under a Section 125 Plan (if available through your employer) for pretax treatment. In addition, coverage of the domestic partner will result in additional imputed taxable income to the employee, and related withholding for payroll taxes (including income and social security taxes).

4. We understand that in addition to the eligibility requirements of the CIS employee Benefits Policy, there are terms and conditions of coverage set forth in the group contract for each health care plan offered through my employer to which we agree to be bound.

5. We understand willful falsification of information contained in this Certificate will result in termination of enrollment under the health care plan(s) we select.

6. We understand that if a payment for an ineligible partner or an ineligible partner's dependent is made, the insurance carrier has the right to recover the payment from the person payment was paid to, or anyone else who benefited from it, including the provider of the services. (The right to recovery includes the right to deduct the amount paid by mistake from the insured member's future benefits).

We certify under penalty of perjury under the laws of the State of Oregon that the foregoing is true and accurate to the best of our knowledge.

______________________________	______________________________	__________
Signature of Employee	Printed Name of Employee	Date
______________________________	______________________________	__________
Signature of Domestic Partner	Printed Name of Domestic Partner	Date

Date Section One Requirements were first met: ________________
Date

Employer Name ______________________________

Employer Address ______________________________

City, State, Zipcode ______________________________