

Employee Information

Name:	Social Security Number:
Day Time Phone:	Employee Number:

Declaration

We, _____ and _____
(Print Employee's Name) (Print Partner's Name)

certify that we are domestic partners in accordance with the criteria set forth below and are eligible for coverage as domestic partners under eFunds benefits.

Status

We certify that:

- We are each other's sole domestic partner and intend to remain so indefinitely;
- We are at least 18 years old (19 for HealthPartners Minnesota) and mentally competent to consent to contract;
- We have been each other's domestic partner for at least six months
- We have resided together in the same principal residence for at least six months and intend to reside together indefinitely;
- We are emotionally committed to one another, financially interdependent, and jointly responsible for each other's common welfare;
- We are not related by blood closer than would bar marriage under applicable law in effect where we reside; and
- We are not married under the common law or the state in which we reside.

Change in Domestic Partner Status

We agree to notify eFunds Corporation by filing a Statement of Termination if there is any change in our status as domestic partners as attested to in this Affidavit. We will notify the Benefits Department within thirty-one (31) days of such change. After termination of this relationship, we understand that a subsequent Affidavit of Domestic Partnership cannot be filed for at least 12 months in accordance with eFunds' enrollment guidelines.

Acknowledgements

We understand that if eFunds Corporation or its employee benefit plan suffer any loss due to any false statement contained in this Affidavit it may bring a civil action against either or both of us to recover its losses, including reasonable attorney's fees.

We have provided the information in this Affidavit for use by eFunds Corporation for the sole purpose of determining eligibility for domestic partner benefits.

We understand and agree that eFunds Corporation cannot guarantee the confidentiality of the information in this Affidavit. We, therefore, agree to waive any privacy rights with respect to this information and to release eFunds Corporation and its plans from liability for its disclosure. We also understand that eFunds will use precautionary measures, as with all personal information, to maintain appropriate confidentiality.

We affirm that the information in this Affidavit is true and complete to the best of our knowledge; we acknowledge and agree to the terms stated herein; and we understand that any misrepresentation may result in loss of benefits and/or termination of employment. We understand that we are subject to the same enrollment requirements as all other employees who are covered by, or applying for, eFunds benefits.

Authorization

We hereby authorize the employee benefit plan to have access to all medical records and hospital, other institution or agency records relating to diagnosis, treatment, or service provided to us to such extent as may be lawfully permitted.

Employee Signature _____ Date _____

Domestic Partner Signature _____ Date _____

Medical Plans Requiring Additional Information

Some medical plan options may require additional documentation to be eligible for benefits. If additional documentation is required, the medical plan will contact you directly. All additional documentation that is requested should be returned to the medical plan directly.

The information about benefits included in this enrollment process is only a brief overview, providing highlights of the eFunds welfare benefit plans. If there are any differences between this overview and the official plan documents, the plan documents will govern. eFunds reserves the right to amend or terminate the welfare benefit plans for any reason and in its sole discretion, and you would be subject to such amendments or termination. For more information contact the Benefits Department.