



9500 Topanga Canyon Blvd.  
Chatsworth, CA 91311  
Tel 800-842-6635  
Fax 818-477-1476  
[local18@mybenefitchoices.com](mailto:local18@mybenefitchoices.com)

Please see enclosed for information about adding a domestic partner during open enrollment.

(Active Employees Open Enrollment is 3/31-4/11/25 and Retirees Open Enrollment is 5/3-5/16/25 for a **July 1<sup>st</sup> effective date**)

Please contact our office if you have any additional questions by calling us at (800) 842-6635 or by email at [local18@mybenefitchoices.com](mailto:local18@mybenefitchoices.com).

Thank you,  
**Local 18 Benefit Service Center**  
9500 Topanga Canyon Blvd.  
Chatsworth, CA 91311

Enclosure

## Domestic Partnership Requirements and Acceptable Proof

### Adding a Domestic Partner during Open Enrollment

Dependent Type	Acceptable Documents
<p><b>Registered Domestic Partner</b></p>	<ul style="list-style-type: none"> <li>• Certificate of Domestic Partnership issued by California Secretary of State, county, or city</li> <li>• An equivalent document issued by:                             <ul style="list-style-type: none"> <li>- Local California agency</li> <li>- Another state, or local agency within another state</li> </ul> </li> </ul>
<p><b>Non Registered Domestic Partner</b></p> <p>You must have <b>lived together</b> for at least <b>12 months</b>. You both must provide acceptable documentation proving you have lived together for at least 12 months.</p> <p style="text-align: center;"><b>AND</b></p> <p>You must complete LADWP’s Affidavit of Domestic Partnership confirming you and your domestic partner meet LADWP’s criteria (see page 5 of this packet from LADWP’s Benefit Guide for more information)</p>	<ul style="list-style-type: none"> <li>- You both will need to provide <b><u>OLD proof</u></b> (12 months or older)</li> </ul> <p style="text-align: center;"><b><u>AND</u></b></p> <ul style="list-style-type: none"> <li>- <b><u>CURRENT proof</u></b></li> </ul> <p>Please see acceptable proof below:</p> <ul style="list-style-type: none"> <li>• <b>California Driver License or identification cards</b> that both share the same address and issue date 12 months or older (<b><u>if this is your current address then NO other document is required</u></b>, if NOT, see other acceptable documents below)</li> </ul> <p style="text-align: center;"><b><u>OR</u></b></p> <ul style="list-style-type: none"> <li>• <b>Utility bill</b> (accepted utilities include water, power, trash, and gas)</li> <li>• <b>Bank statement</b> (without personal info)</li> <li>• <b>Lease agreement/property title/deed</b> (must be the complete lease agreement, signed and dated by all parties)</li> </ul>

**REMINDER: You’ll need to remove your registered or non registered domestic partner within 31 days of ending your domestic partnership and complete a DWP Termination of Domestic Partnership Form. If you marry your domestic partner you need to update his/her status with us, and provide a copy of your marriage certificate.**

**City of Los Angeles**  
**Department of Water and Power**

**AFFIDAVIT OF DOMESTIC PARTNERSHIP**  
**For Health Plan Enrollment Purposes Only**

1. I \_\_\_\_\_ reside with my domestic partner  
Employee Name (print)  
\_\_\_\_\_ at \_\_\_\_\_  
Domestic Partner's Name (print) Address, City, Zip  
and we share the common necessities of life.
2. We have resided together in the same principal residence for at least twelve (12) months.
- 2a. We have resided together since \_\_\_\_\_.  
Beginning Date
3. I affirm that the effective date of this domestic partnership is \_\_\_\_\_.  
Date
4. Neither my domestic partner nor I is married to anyone else.
5. My domestic partner and I are each at least eighteen (18) years of age.
6. My domestic partner and I are not related by blood closer than would bar marriage in the State of California, and each of us is mentally competent to consent to contract.
7. Each of us is the sole domestic partner of the other and each of us is responsible for our common welfare.
8. I agree to notify the Department of Water and Power (Department) within thirty (30) calendar days of any change of circumstances attested to in this Affidavit by filing with the Department of Water and Power, Health Plans Administration Office, a Statement of Termination of domestic Partnership. Such statement of Termination shall be on a Department form provided by the Department of Water and Power, Health Plans Administration Office, and shall affirm under penalty of perjury that the partnership is terminated and that a copy of the Statement of Termination has been mailed to my former domestic partner.
9. I understand and agree that after I have filed such Statement of Termination, I cannot file another Affidavit of Domestic Partnership until twelve (12) months have elapsed.
10. I understand that if the Department suffers any loss because of a false statement contained in this Affidavit of Domestic Partnership, then the Department may bring civil action against me to recover its losses, including reasonable attorney's fees.
11. I understand and agree that I am providing the information in this Affidavit solely to allow the Department to determine my eligibility for the domestic partnership employee health plan benefits as defined by the DWP Health Plans Resolution. I understand and agree that the Department is not legally required to extend any benefits, other than benefits specifically granted

to an employee defined as a domestic partner by the City ordinance and the DWP Health Plans Resolution, as a result of my status as a domestic partner. I understand that the information provided in this Affidavit will be held confidential by the Department, but will be subject to disclosure (a) upon my express written authorization, or (b) pursuant to court order.

12. I understand that the information I am providing in this Affidavit may be used either by my domestic partner or by me as evidence of the existence of my domestic partnership relationship in subsequent legal proceedings. I understand that before signing this Affidavit, I should seek competent legal advice concerning the financial obligations I may be undertaking by signing the Affidavit.
13. I understand that I must pay income taxes on the amount of health and/or dental plan subsidy that will be paid by the Department to provide coverage for my domestic partner and/or the domestic partner's child (ren).
14. I agree that upon termination of this domestic partnership, the Department, its agents, officers, and employees are relieved of any obligation to supply domestic partnership employee benefits to me under any ordinance, memorandum of understanding, or resolution, until the 12 months mentioned in No. 9 above have elapsed and until such time as another domestic partner application is submitted by me and subsequently approved by the Department.
15. I affirm, under penalty of perjury under the laws of the state of California that the assertions in this Affidavit are true to the best of my personal knowledge.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Number

**Wet Signature Required**

**SPECIAL NOTES:**

- *By completing this form, you are only authorizing that health benefits be extended to your domestic partner, and not retirement benefits. If you would like your domestic partner to also receive retirement benefits, you must file a separate affidavit in the Retirement Office in Room 357, (213) 367-1692.*
- *Please submit a copy of your own and your domestic partner's California Driver's License or identification card. Be advised that the addresses on your respective licenses or identification cards must match one another and be the same as your address of record with the Department of Water and Power. Your Affidavit and application cannot be processed until all addresses are consistent.*

# Covering Your Eligible Dependents

If you elect coverage for yourself, you may also elect coverage for your family members who are “eligible dependents.”

## Covering Your Spouse or Domestic Partner

To elect coverage for your spouse or domestic partner, you must submit this documentation to establish eligibility to the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center). If you and your spouse or domestic partner work at LADWP and are eligible for health care coverage, you must each elect coverage; LADWP employees cannot be enrolled as the dependent of another LADWP employee.

Dependent Type	Documents Required for Verifying Eligibility
<b>Spouse</b>	<ul style="list-style-type: none"> <li>&gt; Social Security number</li> <li>&gt; A copy of your certified marriage certificate or</li> <li>&gt; A copy of your temporary marriage certificate.               <ul style="list-style-type: none"> <li>—Your certified marriage certificate must be submitted within 90 days of your marriage. Failure to submit the certified marriage certificate within 90 days of your wedding date will result in termination of enrollment of your spouse including any applicable stepchildren.</li> </ul> </li> </ul>
<b>Registered domestic partner<sup>1</sup></b>	<ul style="list-style-type: none"> <li>&gt; Social Security number</li> <li>&gt; Your Declaration of Domestic Partnership issued by the California Secretary of State, or</li> <li>&gt; An equivalent document issued by:               <ul style="list-style-type: none"> <li>—A local California agency,</li> <li>—Another state, or</li> <li>—A local agency within another state</li> </ul> </li> </ul>
<b>Nonregistered domestic partner<sup>1</sup></b>	<ul style="list-style-type: none"> <li>&gt; Social Security number</li> <li>&gt; Copies of you and your domestic partner’s California driver’s licenses or identification cards and that it matches your address of record with LADWP, or other acceptable written verification showing that you and your domestic partner have been living at the same address for the last 12 months. Proof is required for BOTH you and your domestic partner are receiving service and live at the residence, such as utility bill, bank statement, lease agreement/property title/deed<sup>2</sup></li> <li>&gt; The Affidavit of Domestic Partnership – Health and Dental Enrollment form<sup>3</sup> that provides proof that you and your domestic partner meet LADWP’s required criteria, including:               <ul style="list-style-type: none"> <li>—Neither of you are/were married, in another domestic partnership or covered a spouse or domestic partner during the previous 12 months</li> <li>—You have lived together for the previous 12 months</li> <li>—You are both at least 18 years old</li> <li>—You and your domestic partner are not related by blood closer than would bar marriage in the state of California</li> </ul> </li> </ul>

<sup>1</sup> For domestic partner coverage for Health Plan of Nevada, you must complete a Domestic Partner Rider form.

<sup>2</sup> Utility bills accepted include water, power, refuse and gas. Credit card statements, cable, internet, and phone bills are not accepted. Monthly lease agreements may require additional documentation (ex. notarized letter from property manager or landlord which includes: name(s), move-in date, current residence date, and/or a detailed lease payment ledger.)

<sup>3</sup> The Affidavit of Domestic Partnership – Health and Dental Enrollment form authorizes your domestic partner to receive your health care benefits only.

**PLEASE NOTE:** If you are adding or readding an unregistered domestic partner, employees must wait at least 1 year after a divorce is final or 1 year after their last domestic partnership was terminated.

When an employee submits a document, such as a marriage certificate or birth certificate, in a language other than English, a “Certificate of Accurate Translation” is also required. A Certificate of Accurate Translation, also called “certification statement” is a statement through which the translator verifies the translation issued is complete and accurate.

This certificate is a requirement for certified translations. This certificate includes:

- A statement of the translator’s qualifications
- A statement that confirms the translation is complete and accurate
- A reference to the translated document and the language it is in