CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA
265 Hegenberger Road, Suite 100, Oakland, CA 94621
P.O. Box 2280, Oakland, CA 94614
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
Email: benefitservices@carpenterfunds.com

RE: Carpenters Health and Welfare Trust Fund for California
Domestic Partner Eligibility

Dear Participant:

A Qualified Domestic Partner of an eligible Carpenters Health and Welfare Trust Fund for California participant may become eligible for Health and Welfare benefits subject to satisfaction of certain enrollment and tax payment requirements.

The enrollment procedure for a Domestic Partner will require the following:

1. Complete a new Enrollment Form,

2. Complete a Carpenters Health and Welfare Trust Fund Affidavit of Domestic Partnership,

3. Provide one authenticated document showing joint financial responsibility such as copies of a mortgage, lease, rental agreement, bank statement, or similar documents. The document demonstrating joint financial responsibility shall be satisfactory to the Trustees or their Delegates, and any dispute regarding the authenticity or the adequacy of such documentation shall be resolved by the Trustees.

4. Payment of two months of imputed taxes.

Because the Internal Revenue Service (IRS) does not typically consider Domestic Partners as dependents, the imputed value of Health and Welfare coverage provided to Domestic Partners, whether or not they submit a claim, is taxed. These taxes must be paid before this Fund will grant eligibility to a Domestic Partner. The Fund requires **two months of prepaid taxes.**

PLEASE NOTE: If you claim your registered domestic partner as a dependent, and if your tax advisor has advised that your registered domestic partner qualifies as a dependent under Section 152 (A) of the Internal Revenue Code, and that you are not required to pay Federal Taxes on the imputed value of your Registered Domestic Partner's health coverage – please contact the Trust Fund office for further instructions. Furthermore, if as a same sex couple, or if you are an opposite sex couple and at least one of you is 62 years of age or older, AND you are registered with the State of California and are therefore not required to pay State Taxes on the imputed value of your Registered Domestic Partner's health coverage, please submit supporting documentation for consideration.

A Domestic Partner will be granted eligibility upon satisfaction of the enrollment requirements and payment of the appropriate tax amount (see enclosed rate sheet). Eligibility is granted on the same basis, and provides the same benefits an eligible spouse would receive. Children of Domestic Partners may also qualify for benefits in the same manner until their 19th birthday. In order to qualify for coverage at age 19 (up to their 23rd birthday) they must demonstrate that they are a full-time student at an accredited institution.

Sincerely,
The Board of Trustees

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA
AFFIDAVIT OF DOMESTIC PARTNERSHIP

I, _____ (herein referred to as the Participant), and
_____ (herein referred to as the Partner), hereby declare under penalty of perjury that we are Domestic Partners within the meaning of the following declaration:

1. We have had an intimate, committed relationship of mutual caring for a period of at least six (6) months immediately prior to the date of this Affidavit, and intend to remain sole Domestic Partners indefinitely;
2. We share the same principal residence, with the current intent to continue doing so indefinitely. We agree to be jointly financially responsible for "basic living expenses" defined as the cost of basic food, shelter, and medical expenses. (Note: Domestic Partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.) We agree to provide the Funds Administrative Office with adequate evidence to demonstrate joint financial responsibility. Such evidence may include, without limitation, a copy of a mortgage, lease or rental agreement, bank statements showing joint tenancy in one or more bank accounts, utility statements showing joint financial responsibility for utility payments, or such other documentation as the Trustees may require. In addition to any other applicable requirements, such documentation must show that the Participant and Partner share a joint financial obligation (the Fund's insurance providers may require additional documentation, including additional Affidavits, in order for coverage to become effective). We also hereby certify that we share financial obligations, and any third party who is owed money as the result of a debt incurred during our partnership is entitled to seek and obtain collection from either of us.
3. We are both 18 years of age or older and neither of us is married. Neither of us is related by blood to the other, such as a parent, brother, sister, half-brother or sister, niece, nephew, aunt, uncle, grandparent or grandchild;
4. Neither of us have a different Domestic Partner now, and neither of us has had a different Domestic Partner in the last six (6) months;
5. Participant understands that children of his/her Domestic Partner are eligible for coverage if they are unmarried and meet all of the Fund's other requirements for coverage of an eligible dependent.
6. Participant understands and agrees that coverage for a Domestic Partner shall terminate upon dissolution of the Domestic Partner relationship, and specifically upon a material change in any of the circumstances set forth in paragraphs 1, 2, 3 and 4 of this Affidavit.
7. Each of the Domestic Partners agrees to provide written notice of any change or termination of the Domestic Partner relationship. A "Statement of Termination of Domestic Partnership" will be filed with the Fund Office as soon as possible after such change occurs.
8. After such termination, I understand that an application to add a new Domestic Partner cannot be filed earlier than six months from the filing of a "Statement of Termination of Domestic Partnership";
9. We understand that filing of this Affidavit does not create any right or interest in the Participant's Pension, Annuity, 401(k), or Vacation Benefits, if any; and
10. We understand the Fund will compute the value of the imputed income resulting from the Domestic Partner benefit and that to receive coverage we will be required to remit payment of these taxes on this amount to the Fund. **PLEASE NOTE:** If you claim your Registered Domestic Partner as a dependent, and if your tax advisor has advised that your Registered Domestic Partner qualifies as a dependent under Section 152 (A) of the Internal Revenue Code, and that you are not required to pay Federal taxes on the imputed value of your Registered Domestic Partner's health coverage – please contact the Trust Fund office for further instructions. Furthermore, if as a same sex couple, or if you are an opposite sex couple and at least one of you is 62 years of age or older, AND you are registered with the State of California and are therefore not required to pay State Taxes on the imputed value of your Registered Domestic Partner's health coverage, please submit supporting documentation for consideration.

<u>IMPORTANT:</u> We acknowledge that in most cases a partner does not qualify as a dependent of the Participant as defined by Section 152(A) of the Internal Revenue Code. By requesting enrollment of a partner under this Affidavit of Domestic Partnership, each of us understands that the Carpenters Health and Welfare Trust Fund for California must report imputed taxable income to the Internal Revenue Service for coverage under the Fund.

Each of us understands these rules and declares that the statements outlined above are true and correct with regards to the Participant's and Partner's Domestic Partner relationship. We understand that if the Fund, or their agents suffer any loss due to an inaccurate statement in this Affidavit, they may bring a civil action against either or both of us to recover their losses, including reasonable attorney's fees.

We understand that the information contained in this Affidavit will be held confidential and will be subject to disclosure only upon the express written authorization of the Participant or as required by law. We declare under penalty of perjury that each of the statements made herein are true and correct.

In providing Domestic Partner benefits, the Trustees recognize that participants may have tax or benefit implications. Contact your tax advisor for professional advice as to how Domestic Partner coverage may affect you.

****SIGNATURES MUST BE NOTARIZED****

_____ _____

Participant's Signature Date

_____ _____

Domestic Partner's Signature Date

Address: _____

Participant's CFAO ID, UBC# or SS# _____ Phone No: _____

NOTARY ACKNOWLEDGMENT:

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____

County of _____

On _____ before me, _____, Notary Public,
Date Here Insert Name and Title of the Officer

personally appeared _____
Name(s) of Signer(s)

_____

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

Place Notary Seal Above

MONTHLY DOMESTIC PARTNER IMPUTED TAXES - 2018

Active Participant	
- Adding Domestic Partner Only	$229.00
- Adding Domestic Partner with Children	$388.00
Retiree Non-Medicare Domestic Partner with Kaiser	
- Adding Domestic Partner Only	$379.00
- Adding Domestic Partner with Children	$693.00
Retiree Non-Medicare Domestic Partner with Indemnity Medical Plan	
- Adding Domestic Partner Only	$361.00
- Adding Domestic Partner with Children	$472.00
Retiree Medicare Coordinated Domestic Partner	
- Indemnity	$125.00
- Kaiser Senior Advantage	$134.00

Note: If you are a Retiree enrolling a Domestic Partner, you will be responsible for both your Retiree coverage monthly premium for yourself and dependent(s) and the applicable imputed tax amount.

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Oakland, California 94621-0180
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GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

The Carpenters Health and Welfare Trust Fund for California ("Fund" or "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Pauline Hann, Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Pauline Hann, Civil Rights Coordinator
Carpenter Funds Administrative Office of Northern California, Inc.
265 Hegenberger Rd., Suite 100
Oakland, CA 94621
Telephone number: (888) 547-2054, Fax: (510) 633-0215
Email: benefitservices@carpenterfunds.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pauline Hann, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (888) 547-2054. (TTY: 888-547-2054).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-547-2054（TTY：1-888-547-2054).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-547-2054 (ATS : 1-888-547-2054).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-547-2054 (TTY: 1-888-547-2054).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-547-2054 (TTY: 1-888-547-2054).
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-547-2054 (TTY: 1-888-547-2054).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-547-2054 (TTY: 1-888-547-2054).
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-547-2054 (TTY: 1-888-547-2054) تماس بگیرید.
Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-547-2054 (TTY: 1-888-547-2054) पर कॉल कर।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-547-2054 (TTY: 1-888-547-2054).
Navajo	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-888-547-2054 (TTY: 1-888-547-2054.)
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-547-2054 (رقم هاتف الصم والبكم: 1-888-547-2054).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-547-2054 (TTY: 1-888-547-2054) 번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-547-2054 (TTY: 1-888-547-2054).
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-547-2054 (TTY: 1-888-547-2054).