

Please return completed form to your District Benefits Administrator.

# Common Law Spouse Declaration

## Employee Common Law Spouse Declaration

Employee's Last Name	First Name	Initial	District #
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Please insure my common law spouse, \_\_\_\_\_ for the following benefits as of \_\_\_\_\_:  
(full name of common law spouse) (Coverage effective date)

- Extended Health Care
- Dental Care

Date co-habitation began: \_\_\_\_\_

**Common law spouse definition:** A person of the opposite or same sex, who has been residing with the Employee for a continuous period of at least 1 year, and is publicly represented as the Employee's spouse.

I hereby certify that my spouse meets the definition of common law spouse as defined above.

Employee Signature \_\_\_\_\_ Date Signed (yyyy/mm/dd) \_\_\_\_\_