Exhibit B

Health Coverage For Domestic Partners

An Employee may provide coverage for an eligible Domestic Partner and/or the Partner's Eligible Dependent Children by submitting appropriate enrollment forms within required timelines.

Eligibility

VEBA offers Domestic Partner Coverage under either of the following two eligibility provisions:

1. Employees may qualify for Domestic Partner Coverage by having registered the Domestic Partnership with the State of California and providing to the VEBA, a copy of the registration.

2. An Employee who has not registered the Domestic Partnership with the State of California may qualify for Domestic Partner Coverage by meeting the requirements of, and filing, a Declaration of Domestic Partnership with the VEBA.

Possible Tax Implications of Domestic Partner Coverage

1. An Employee who provides Domestic Partner coverage will have added to his/her taxable income for purposes of federal income taxation, the fair market value of the health coverage accorded the Domestic Partner and/or his/her Dependents, (less any contribution paid by the Employee for this coverage) subject to withholding, unless it can be demonstrated that the Domestic Partner and/or his/her Dependents qualify as a Dependent of the Employee for federal income tax purposes.

2. State taxes may apply if the Employee and Domestic Partner fail to register with the state of California or other applicable state where they reside.

3. An Employee may want to consult an attorney concerning any possible income tax implications of providing Domestic Partner coverage.

4. Neither the District nor the Southern California Schools Voluntary Employees Benefits Association or any employee or agent can definitely identify the tax consequences.

Enrollment Process and Timelines

For Domestic Partners **registered with the State of California**, a properly completed enrollment form and copy of the registration endorsed as filed by the California Secretary of state must be submitted to the Employer/Plan Administrator within the following required timelines:

1. 31 days of the date of hire, or

2. for a continuing Employee newly eligible to enroll for benefits coverage, within 31 days of attaining eligibility, or

3. within 31 days of registration with the State of California, or

4. the Employer's annual Open Enrollment Period; the effective date must coincide with the beginning of the Employer's Plan Year.

An Employee who **has not registered the Domestic Partnership** with the State of California may enroll under this option only during the Employer's Annual Open Enrollment period by submitting the required forms and attachments to the Employer/Plan Administrator. (See the attached Declaration of Domestic Partnership form for requirements.)

Cessation of Domestic Partner Coverage

The Employee and/or the Domestic Partner have a responsibility to notify the Employer/Plan Administrator of the termination of the Domestic Partnership within (30) days of the first to occur of the following:

1. The death of the Domestic Partner

2. The date on which any of the criteria of a Domestic Partnership relationship is no longer met

If the Employee fails to make the required notification, the Employee will be liable for any expenses incurred by the VEBA with respect to the former Domestic Partner or his/her Dependents after the termination of the Partnership and must reimburse the VEBA for the value of those benefits. The VEBA shall have the right to recover attorney fees and costs incurred in collecting such expenses from the Employee**.**

Coverage for a Domestic Partner and his/her Eligible Dependent Children will cease on the first to occur of the following:

1. The end of the month in which the death of the Domestic Partner occurs

2. The end of the month in which one or more of the criteria of Domestic Partnership is no longer met

3. The end of the month for which a required Employee contribution is made for coverage for a Domestic Partner or his/her Dependents

Under current law, a Domestic Partner and his/her Dependents are not eligible for COBRA continuation coverage upon cessation of VEBA coverage; however a limited conversion plan may be available through the medical plan carrier.

Declaration of Domestic Partnership

I, _____, submit this Declaration of Domestic Partnership to establish
(Name of Employee)

_____ as my Domestic Partner (as this term is defined
(Name of Domestic Partner)

below) for the purpose of qualifying for any benefits that the District may extend to employees in a Domestic Partnership.

I, _____, declare and acknowledge as follows:
(Name of Employee)

I and _____ are Domestic Partners.
(Domestic Partner)

"Domestic Partners" means two adults of the same or opposite sex who have chosen to share their lives in an intimate and committed relationship, reside together, and share a mutual obligation of support for the basic necessities of life.

Specifically, I declare and acknowledge that I and my Domestic Partner named above meet all of the following criteria:

- Are both at least 18 years old, and
- are not legally married to anyone, and
- have had at least twelve complete months between the date of the termination of any prior marital status or domestic partner relationship and the date the domestic partner application is submitted, and
- reside in the same residence, with the intent to reside together permanently, and
- have the mental competence to contract, and are not related by blood to the degree that would bar marriage under California law, and
- have resided together continuously for the twelve complete months preceding application for coverage, and
- have agreed to be jointly responsible for basic living expenses, including food, shelter, and other expenses of the joint household, and
- have terminated any prior domestic partnership at least twelve complete months prior to application for coverage, and
- have filed a fully complete application, together with attachments.

This Application must be accompanied by any one of the following to establish joint residence:

- Copies of driver's licenses for both individuals which contain the same address, or
- Mortgage documents or deed containing the names of both individuals, or
- Rental lease agreement containing the names of both individuals.

This Application must be accompanied by any one of the following to establish financial interdependence:

- Joint checking or savings account, or
- Credit cards with the same account number in both names, or
- Common ownership of real property or a common leasehold interest in real property, or
- Common ownership in a motor vehicle, or
- Joint wills in which one partner is the primary beneficiary under the other partner's will, or

- Designation of both partners as authorized signatories on safe deposit boxes, or
- Designation of the Domestic Partner as the beneficiary under the Employee's life insurance plan.

I acknowledge that:

- I cannot file another Declaration of Domestic Partnership for a new Domestic Partnership until at least twelve months after a Statement of Termination of Domestic Partnership has been filed.
- If requested, I will provide to the District's Plan Administrator or designated representative documents establishing the existence of my Domestic Partnership relationship.
- Neither the District nor the Southern California Schools Voluntary Employees Benefits Association is providing legal advice and that I have been advised to consult an attorney regarding the possible legal implications of filing this Declaration of Domestic Partnership.
- I have an obligation to file a Statement of Disenrollment, Death, or Termination of Domestic Partnership with the District's Plan Administrator or designated representative within [30] days of the earliest of (a) the death of my Domestic Partner; (b) the date on which any of the criteria of a Domestic Partnership relationship is no longer met. I further understand that the effective date of the end of the Domestic Partnership relationship is the earliest of (a) the death of my Domestic Partner; (b) the date on which I file a Statement of Disenrollment, Death or Termination of Domestic Partnership with the District's Plan Administrator or designated representative; (c) the date on which the Domestic Partner notifies the Plan of the termination of the Domestic Partnership; (d) the date on which one or more of the criteria of Domestic Partnership are no longer met.
- I understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statement contained in this Declaration of Domestic Partnership, including claims paid under any benefit plans in which I enroll my Domestic Partner and/or child(ren) of a Domestic Partner. The Plan shall have the right to recover attorney fees and costs incurred in collecting such expenses from me.

I declare, under penalty of perjury, that the foregoing is true and correct that this Declaration was executed on _____ at _____, California.

Dated:_____ _____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, ZIP Code)

_____
(Name of Domestic Partner)

Domestic Partner
Health Care Enrollment Statement

To enroll _____, and/or his or her eligible dependent
(Name of Domestic Partner)

children, if any, in the District's group health care coverage that, subject to certain limitations, covers District employees and their Domestic Partners, I declare and acknowledge my understanding that:

- The options under the group health coverage currently available to employees who choose to enroll their Domestic Partners and/or child(ren) of Domestic Partners may be more limited than those available to other employees (i.e., limited to medical, dental, and vision coverage only).

- All group health coverage is governed by the terms of the underlying plan(s) ("Plan").

- If I choose to enroll only the child(ren) of my Domestic Partner, I understand that my Domestic Partner may not subsequently enroll in the group coverage until a future District annual enrollment period.

- The effective date of coverage may only coincide with the District's annual health care re-enrollment date next following the timely receipt of my signed election.

- Unless my Domestic Partner and/or child(ren) of my Domestic Partner also are considered my dependent for tax purposes under Section 152 of the Internal Revenue Code, the Internal Revenue Service currently treats as imputed income to the employee the value of the health coverage provided the Domestic Partner's dependents, if any, less any contribution paid by the employee for this coverage. I reviewed the examples of imputed income amounts for group health coverage detailed in the cover letter to this Statement.

  I understand that I should consult an attorney concerning the income tax implications of filing this Statement and that neither the District, the Southern California Schools Voluntary Employees Benefits Association nor any employee or agent can definitely identify the tax consequences.

- I have an obligation to file a statement of Disenrollment, Death or Termination of Domestic Partnership with the District's Plan Administrator or designated representative within [30] days of the earliest of (a) the death of my Domestic Partner, or (b) the date on which any of the criteria of a Domestic Partner relationship is no longer met.

- Regardless of whether the requisite Statement of Disenrollment, Death or Termination of Domestic Partnership has been filed, the effective date of the end of the Domestic Partner relationship, and, therefore, the date on which coverage of my Domestic Partner and his or her dependent children, if any, will end, according to the terms of the Plan, is the earliest of:

  — the date on which my Domestic Partner dies;
  — the date on which my Domestic Partner and I terminate our Domestic Partnership;
  __ the date on which one or more of the criteria of Domestic Partnership are no longer met; or
  __ the date on which I file a Statement of Disenrollment, Death, or Termination of Domestic Partner with the District's Plan Administrator or designated representative.

I affirm that the statements in this Statement are true to the best of my knowledge.

DATED:_____

_____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, ZIP Code)