



Health Benefit Services Division
P.O. Box 942714
Sacramento, CA 94229-2714

Toll Free: (800) 237-3345 Local: (916) 326-3970
TDD: (916) 326-3240 Fax: (916) 658-1313

Statement of Financial Liability For Domestic Partner Health Benefits

I, _____ agree that I may be required to
(Full Name of Subscribing Individual)
reimburse my employer, my designated health benefits plan, and the California Public Employees' Retirement System, for any expenditures made by my employer, my designated health benefits plan, and the California Public Employees' Retirement System, for medical claims, processing fees, administrative charges, costs, and attorney's fees incurred in conjunction with providing health coverage under the Public Employee's Medical and Hospital Care Act to my domestic partner or any of his or her dependents if any of the submitted documentation is found to be incomplete, inaccurate, or fraudulent.

Full Name of Subscriber _____

Signature _____

Full Name of Domestic Partner _____

**California State University
Statement of Financial Liability
For
Domestic Partner Dental and Vision Benefits**

I, _____, agree that I may be required to
(Full Name of Employee)
reimburse The California State University (CSU), my designated dental benefits
plan, and/or my designated vision benefits plan for any expenditure made by the CSU,
my designated dental benefits plan, and/or my designated vision plan for dental and/or
vision claims, processing fees, administrative charges, costs, and attorney's fees incurred
in conjunction with providing dental and/or vision coverage pursuant to HR 2000-01,
under the standard eligibility rules of the Public Employees' Medical and Hospital Care
Act (PEMHCA), to my domestic partner or any of his or her dependents if any of the
submitted documentation is found to be incomplete, inaccurate, or fraudulent.

Full Name of Employee _____

Signature _____

Date _____

Full Name of Domestic Partner _____