

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

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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)
reim	burse 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 o	designated dental benefits plan, and/or my designated vision plan for dental and/or
visio	on claims, processing fees, administrative charges, costs, and attorney's fees incurred
in co	onjunction with providing dental and/or vision coverage pursuant to HR 2000-01,
unde	er 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
subn	nitted documentation is found to be incomplete, inaccurate, or fraudulent.
Full	Name of Employee
	Signature
	Date
Full	Name of Domestic Partner