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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 reimburse the employer
(Full Name of Subscribing Member)

my designated health services plan, and the California Public Employees' Retirement System, for any expenditures made by the employer, my designated health services plan, and the California Public Employees' Retirement System, for medical claims, processing fees, administrative charges, costs, and attorney's fees on behalf of the domestic partner if any of the submitted documentation is found to be incomplete, inaccurate, or fraudulent.

Full Name of Subscriber _____

Signature_____

Full Name of Domestic Partner _____

Signature_____

Full Name of Witness _____

Signature_____