COUNTY OF SUFFOLK

EDWARD P. ROMAINE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HUMAN RESOURCES
EMPLOYEE MEDICAL HEALTH PLAN

JOSEPH LAMBERSON
DIRECTOR

ELIGIBILITY CRITERIA FOR DOMESTIC PARTNERSHIP COVERAGE*

The Employee Medical Health Plan (EMHP) Labor/Management Committee has offered health benefits coverage, effective September 1, 2004, to same or opposite sex domestic partners of covered members if they meet certain criteria.

A domestic partnership, to be covered by EMHP, is one in which the covered member and domestic partner:

- are 18 years of age or older,
- are unmarried and not related in a way that would bar marriage in the State of New York,
- have a close and committed personal relationship,
- are living together and have been living together on a continuous basis,
- are registered with the Employee Benefits Unit as domestic partners,
- have not terminated the domestic partnership, and
- have been in a partnership and are able to provide proof of residency and financial interdependence for at least six months.

To cover a domestic partner's child, the standard provisions for adding a dependent apply.

Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of the health benefits is treated as income for tax purposes when a person who is not a qualified dependent under Federal IRS rules is covered under EMHP. Please ask your tax consultant how enrolling your domestic partner will affect your taxes.

If the partnership ends, the member must notify the Employee Benefits Unit and end coverage for their domestic partner. The domestic partner may be eligible to continue coverage on a self-pay basis. There will be a one-year waiting period from the termination date of a previous partner's or ex-spouse coverage before the member may again enroll a domestic partner.

Members who fraudulently enroll a domestic partner, or who fail to notify EBU of the termination of a domestic partnership, are held financially and legally responsible for any benefits paid and are subject to disciplinary action. Such members may forfeit future coverage.

If the member dies, the surviving domestic partner's health coverage and the domestic partner's children's health coverage will be enrolled as dependent survivors. Surviving dependent children will be eligible until age 26 under the rules of PPACA.

Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner of an active employee becomes Medicare eligible due to disability, EMHP is primary.

If a member or a member's domestic partner has specific questions as to coverage under EMHP, contact the Employee Benefits Unit.

Please return forms to address listed below.

Although not covered by COBRA, this is intended to provide continuation benefits comparable to COBRA benefits in all respects.

01/2024

LOCATION:
WILLIAM J. LINDSAY COMPLEX – BLDG. 158
725 VETERANS MEMORIAL HIGHWAY

MAILING ADDRESS:
P.O. BOX 6100
HAUPPAUGE, NY 11788-0099

(631) 853-4866
FAX: (631) 853-6396

HOW TO ENROLL A DOMESTIC PARTNER

1. Complete the following forms:

   - Health Insurance Transaction Form

     1. Complete entire Section 1 with your personal data. In Box 6, you would check "Domestic Partner".
     2. Complete Section 3, Box 14, indicating reason as "adding domestic partner/dependents" and indicating date of event.
     3. Complete Section 4, indicating information for both domestic partner and additional domestic partner dependents, including relationship, date of birth and social security number. When adding Domestic Partner dependent children, you must submit an Affidavit of Dependency along with a copy of their birth certificate. If the dependent child is a full-time student between the ages of 19 and 25, you must also submit either a "Verification of Student Status" form or the student's class schedule indicating the student's name, college name, semester and number of credits. Please make sure your name and social security number are on these forms. If you submit the student's class schedule, you must provide documentation for proof of payment.
     4. Sign and date "Request to Participate", located under Section 4.
     5. If your Domestic Partner or their dependents have other coverage, complete Section I with pertinent information, and sign and date.
     6. **Domestic Partner Social Security Card**

   - Application for Health Benefits for Domestic Partners of Enrollees of any of the Suffolk County Provided Health Plans and Affidavit of Domestic Partnership forms, with appropriate documentation indicated in form for at least six months.

   - Affidavit of Financial Interdependence for Enrollees of Any of the Suffolk County Provided Health Plans form, with appropriate documentation indicated in form for at least six months.

   NOTE: If you have any questions while completing these forms, you may call the Employee Benefits Unit for assistance at (631) 853-4866, or contact them via e-mail at ebu@suffolkcountyny.gov.

2. In addition to the above, IF your partner qualifies as your dependent for federal tax purposes and you wish to avoid the additional taxes that may result from this benefit, you must also complete the Dependent Tax Affidavit for Enrolling Domestic Partners of Enrollees of Any of the Suffolk County Provided Health Plans form and return it with the other forms and documents. It is recommended that you seek the advice of an attorney and/or tax consultant to determine how enrolling your domestic partner will affect your taxes.

3. Return the completed forms and documents, including the **REQUIRED PROOFS OF RESIDENCE AND FINANCIAL INTERDEPENDENCE** to the:

   Employee Benefits Unit
   S.C. Department of Civil Service/Human Resources
   Division of Employee Services
   P. O. Box 6100
   Bldg. #158, William J. Lindsay County Complex
   Hauppauge, NY 11788-0099

Applications filed without the required affidavit or proofs will not be processed. Ambiguity or lack of clarity will not be interpreted in the employee's/partner's favor.

(over)

HOW TO REPORT THAT THE PARTNERSHIP HAS ENDED

You must complete and submit the form, "Termination of Domestic Partnership of Enrollees of Any of the Suffolk County Provided Health Plans" within fourteen (14) days of the date that the partnership ends. Please contact the Employee Benefits Unit to request this form, via e-mail at ebu@suffolkcountyny.gov, or via telephone at (631) 853-4866.

If you do not file the form on a timely basis, you may be held financially and legally responsible for any benefits paid on and after the date the partnership ended and you may be subject to disciplinary action.

You may not enroll another domestic partner, or re-enroll the same domestic partner, until one year after the termination date of your previous partner's coverage. Your former partner's 60 day eligibility period for applying for COBRA continuation coverage starts on the date the relationship terminates, not the notification date.

EMPLOYEE MEDICAL HEALTH PLAN SUFFOLK COUNTY
HEALTH BENEFITS TRANSACTION FORM

INSTRUCTIONS:
NEW ENROLLMENT - FILL OUT SECTION 1, 2, AND 4
CHANGE IN STATUS - FILL OUT SECTION 1, 3, AND 4

SECTION 1

① LAST NAME | FIRST NAME | MI
④ ENROLLEE'S SOCIAL SECURITY NUMBER
⑤ ENROLLEE'S DATE OF BIRTH MONTH DAY YEAR
② STREET ADDRESS
⑥ MARITAL STATUS ☐ (1) SINGLE ☐ (2) MARRIED ☐ (3) WIDOWED ☐ (4) DIVORCED ☐ (5) DOMESTIC PARTNER
P. O. BOX RURAL ROUTE
⑦ ENROLLEE'S SEX ☐ (1) MALE ☐ (2) FEMALE
⑧ SPOUSE/PARTNER'S SOCIAL SECURITY #
③ CITY | STATE | ZIP CODE
SPOUSE/PARTNER'S EMPLOYER
HOME PHONE NO. | BUSINESS PHONE NO. | SPOUSE/PARTNER'S PHONE NO.

THIS SECTION TO BE COMPLETED BY NEW EMPLOYEE

SECTION 2

⑨ ☐ EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY ☐ HMO SPECIFY HMO OTHER
⑩ COVERAGE ☐ (1) INDIVIDUAL ☐ (2) FAMILY (LIST ELIGIBLE DEPENDENTS IN SECTION 4 BELOW)
⑪ PREVIOUS COVERAGE COMPLETE ONLY IF COVERAGE UNDER YOUR PREVIOUS HEALTH INSURANCE HAS TERMINATED OR WILL TERMINATE WITHIN TWO MONTHS
PREVIOUS COVERAGE WAS AS A(N) ☐ ENROLLEE ☐ DEPENDENT
NAME OF ENROLLED EMPLOYEE | REASON FOR TERMINATION OF COVERAGE
NAME OF EMPLOYING AGENCY | PREFIX | IDENTIFICATION NUMBER OF EMPLOYEE | COVERAGE TERM DATE MONTH DAY YEAR

THIS SECTION TO BE COMPLETED FOR A CHANGE IN STATUS

SECTION 3

⑫ OPTION CHANGE TO ☐ EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY ☐ HMO SPECIFY HMO SPECIFY HMO
⑬ ☐ CHANGE TO INDIVIDUAL COVERAGE REASON | DATE OF EVENT MONTH DAY YEAR
⑭ ☐ CHANGE TO FAMILY COVERAGE REASON (LIST ELIGIBLE DEPENDENTS IN SECTION 4 BELOW) | DATE OF EVENT MONTH DAY YEAR
⑮ ☐ NAME CHANGE PREVIOUS NAME WAS LAST NAME | FIRST NAME | MI.
⑯ ☐ CANCELLATION I VOLUNTARILY CANCEL MY HEALTH INSURANCE FOR MYSELF AND MY DEPENDENTS SIGNATURE X | DATE SIGNED MONTH DAY YEAR

IF YOU APPLIED FOR FAMILY COVERAGE, LIST ALL ELIGIBLE DEPENDENTS HERE (including spouse or domestic partner)

SECTION 4

⑰ FULL NAME LAST NAME	FIRST NAME	MI.	RELATIONSHIP	DATE OF BIRTH	DEPENDENT'S SOC. SEC. NO.	SCHOOL OR COLLEGE	DATE ENROLLED	ANTICIPATED DATE OF GRAD

⑱ ☐ REQUEST TO PARTICIPATE

I certify that the information supplied by me is true and correct, I understand that it is solely my responsibility to timely notify, in advance where possible, Suffolk County of any changes that may affect coverage of myself or of any of my enrolled dependents. I further understand that my failure to so timely notify Suffolk County of any change in status that would affect coverage shall render me solely responsible for reimbursing the County for any claims paid on behalf of an ineligible enrollee or dependent. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims.

Signed ______________________ Date __________
Signature of employee

☐ WAIVER OF BENEFITS

I do not participate in the Employee Medical Health Plan of Suffolk County offered through my employer, and I understand that I may subject myself and/or my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.

Signed ______________________
Signature of employee
Date __________

FOR AGENCY USE ONLY

SECT 5

⑲ TXN CODE | ⑳ TXN EFFECTIVE DATE MONTH DAY YEAR | ㉑ FUND/APPR | ㉒ DEPT NAME | ㉓ DATE EMPLOYED MONTH DAY YEAR | ㉔ DATE OF FIRST ELIBILITY MONTH DAY YEAR
㉕ DATE EMPLOYMENT TERM MONTH DAY YEAR | ㉖ DATE ELIGIBILITY LOST MONTH DAY YEAR | ㉗ NEG UNIT | ㉘ NAME OF RETIREMENT SYSTEM | ㉙ DATE RETIRED MONTH DAY YEAR | ㉚ DATE OF DEATH MONTH DAY YEAR

CCMS - 014

EMPLOYEE MUST COMPLETE REVERSE SIDE

SCER #001

HEALTH INSURANCE COORDINATION OF BENEFITS FORM

The EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY has a Coordination of Benefits Provision that applies when you or any dependent receive benefits under more than one health insurance program. Coordinating benefits helps to contain the cost of health care and can save you some out-of-pocket expenses when balances remain after one carrier has made its claim payment. New employees should return the completed form to their Payroll Office. All others, please return completed form to the Employee Benefits Unit, P.O. Box 6100, Bldg. # 158, North County Complex, Hauppauge, NY 11788-0099.

SECTION I.

OTHER COVERAGE A:

NAME OF DEPENDENT WITH OTHER COVERAGE (including spouse or domestic partner)	POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH	SEX
NAME OF OTHER EMPLOYER	ADDRESS OF OTHER EMPLOYER		
NAME OF OTHER INSURANCE CARRIER	ADDRESS OF OTHER INSURANCE CARRIER		
TYPE OF COVERAGE ☐ Individual ☐ Family	COMMENTS:		
EFFECTIVE DATE	TERMINATION DATE		

OTHER COVERAGE B:

NAME OF DEPENDENT WITH OTHER COVERAGE (including spouse or domestic partner)	POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH	SEX
NAME OF OTHER EMPLOYER	ADDRESS OF OTHER EMPLOYER		
NAME OF OTHER INSURANCE CARRIER	ADDRESS OF OTHER INSURANCE CARRIER		
TYPE OF COVERAGE ☐ Individual ☐ Family	COMMENTS:		
EFFECTIVE DATE	TERMINATION DATE		

IF ADDITIONAL DEPENDENTS HAVE OTHER COVERAGE, CHECK HERE ☐

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION: This information will be used in accordance with Section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (f). Failure to provide this information may result in a delay in payment of benefits.

FOR FURTHER INFORMATION ON THE COORDINATION OF BENEFITS FORM CONTACT YOUR PERSONNEL OFFICE
I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

Signature ______________________________ Date ________________

S.C. Department of Civil Service/Human Resources
Employee Benefits Unit
P. O. Box 6100, Veterans Memorial Highway
Bldg. #158, William J. Lindsay County Center
Hauppauge, NY 11788-0099
e-mail address: ebu@suffolkcountyny.gov
631-853-4866

Application for Health Benefits for Domestic Partners of Enrollees of any of the Suffolk County Provided Health Plans And Affidavit of Domestic Partnership

STATE OF: ______________________)

)ss.:

COUNTY OF: ____________________)

The undersigned, being duly sworn, depose and declare as follows:

1. We are both eighteen (18) years of age or older and unmarried. If either or both of us has been married, we submit evidence of the termination of the marriage.
2. We are not related by blood in a manner that would bar marriage under the laws of the State of New York.
3. We are each other's sole domestic partner, have been so for at least six months prior to the date of this affidavit, and intend to remain so indefinitely. We are in a relationship of mutual support, caring and commitment, and have assumed responsibility for each other's welfare.
4. We have been living together on a continuous basis for at least six months prior to the date of this affidavit. (See reverse side for proof of residency.)
5. One of us is enrolled in a County provided health plan.
6. Neither of us has been registered as a member of another domestic partnership within the last year.

** Upon filing a certificate of domestic partnership/civil union, from an authorized jurisdiction, the enrollee and domestic partner do not have to complete the "Affidavit of Financial Interdependence. You must complete the Affidavit of Financial Interdependence and provide the appropriate supporting documentation.*

I, the enrollee, affirm that I will file a Termination of Domestic Partnership form within 14 days of the date I/my partner no longer meets one or more of the qualifying criteria set forth above.

(over)

I, the enrollee, understand that any false or misleading statement made in order to receive benefits for which I or my domestic partner do not qualify will subject **me** to financial responsibility for any benefits paid on behalf of my partner, or his/her dependent child(ren) and/or other legal actions appropriate to the prosecution of such fraud.

Print Name (Enrollee): ______________________ Print Name (Partner): ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Signature (in presence of notary): ______________________ Signature (in presence of notary): ______________________

Sworn to before me this _____ day of _________, 20__

____
(Notary Public)

PROOF OF RESIDENCY

To enroll your domestic partner in a Suffolk County provided health plan, you must submit a copy of one item of proof that you and your partner have resided together for at least six months. The proof may be one document with both names or two separate documents that show the residence of each partner.

The following is a list of some items that can be used to demonstrate proof of residency. You may submit a copy of another document that proves residency began at least six months ago.

- ☐ Driver's license
- ☐ Auto registration
- ☐ Lease agreement listing both parties
- ☐ Mortgage agreement listing both parties
- ☐ Tax return
- ☐ Bank statement
- ☐ Passport
- ☐ Insurance benefits statement
- ☐ Pay check stub
- ☐ Utility bill
- ☐ Telephone bill
- ☐ Joint membership (e.g., church or family association)

S.C. Department of Civil Service/Human Resources
Employee Benefits Unit
P. O. Box 6100, Veterans Memorial Highway
Bldg. #158, William J. Lindsay County Center
Hauppauge, NY 11788-0099
e-mail address: ebu@suffolkcountyny.gov
631-853-4866

Affidavit of Financial Interdependence for Enrollees of Any of the Suffolk County Provided Health Plans

STATE OF: _______________)
)ss.:
COUNTY OF: ______________)

The undersigned, being duly sworn, depose and declare as follows:

We are domestic partners who reside together and are financially interdependent. We submit complete, clear and legible copies of documents of two of the following items (at least one of the two items must be from List A) as proof of our financial interdependence, ***one copy current, and one copy dating back a minimum of six months***:

(Note: Incomplete, illegible copies or partial documents may delay the processing of your application for coverage. If you submit original documents, be advised that they will not be returned to you.)

LIST A

- ☐ Joint obligation on a loan (including an affidavit by a creditor for a personal loan)
- ☐ Joint ownership of our residence
- ☐ Joint renters' or homeowners' insurance policy
- ☐ Joint responsibility for child care (e.g., school documents, guardianship)
- ☐ Mutually granted durable powers of attorney, designating each other as primary attorney-in-fact
- ☐ Designation of one partner as the representative payee for the other's government benefits
- ☐ Joint ownership or holding of investments
- ☐ Joint ownership or lease of a motor vehicle
- ☐ Both listed as tenants on the lease of our shared primary residence
- ☐ Mutually granted authority to make health care decisions, designating each other as primary health care attorney-in-fact (e.g. health care proxy/power of attorney)
- ☐ Share a household budget for the purpose of receiving government benefits
- ☐ Most recent federal tax return on which I claim my partner as a dependent for federal tax purposes.
- ☐ Mutually designated as primary beneficiary under the other's life insurance policy, retirement benefits account or Will (residual beneficiary would not suffice) or primary executor of each other's Will

(over)

<u>LIST B</u>

- ☐ Joint bank account
- ☐ Joint credit or charge card(s)
- ☐ Status as authorized signatory on the partner's bank account, credit card or charge card
- ☐ Other acceptable proof establishing economic interdependence (*Mutual Powers of Attorney, Joint Wills, Mutual designations as Authorized signatures on Safe Deposit Boxes).*

NOTE: Proof submitted from list A and list B must show financial interdependence for at least <u>six months</u>.

All documentation is subject to review and interpretation by the County of Suffolk, Department of Civil Service, Employee Benefits Unit, as to its applicability and sufficiency of satisfying the foregoing requirements.

Print Name (Enrollee):

____

Address:

____

____

Signature (in presence of notary):

____

Print Name (Partner):

____

Address:

____

____

Signature (in presence of notary):

____

Sworn to before me this _____ day of ________, 20__

____
(Notary Public)

S.C. Department of Civil Service/Human Resources
Employee Benefits Unit
P. O. Box 6100, Veterans Memorial Highway
Bldg. #158, William J. Lindsay County Center
Hauppauge, NY 11788-0099
e-mail address: ebu@suffolkcountyny.gov
631-853-4866

DEPENDENT TAX AFFIDAVIT* FOR ENROLLING DOMESTIC PARTNERS OF ENROLLEES OF ANY OF THE SUFFOLK COUNTY PROVIDED HEALTH PLANS

***It is recommended that you seek the advice of your attorney and/or tax consultant prior to completing this affidavit.**

STATE OF: ______________________

COUNTY OF: ____________________

SS.:

The undersigned, being duly sworn, deposes and declares as follows:

My domestic partner,

____/____,
(Partner's Name) (Partner's Social Security Number)

fully qualifies as my dependent under Internal Revenue Code rule 152. I understand that if my partner's dependent status under IRC 152 changes at any time during the tax year, I will be responsible for reporting and paying tax on any resulting imputed income. (See reverse side for definitions in Internal Revenue Code rule 152.)

Print Name (Enrollee): ________________________________

Social Security Number: ________________________________

Address: ________________________________

____

Signature (in presence of notary): ________________________________

Sworn to before me this _____ day of _________, 20__

____
(Notary Public)

(over)

DEFINITIONS IN INTERNAL REVENUE CODE RULE 152

The following are definitions extracted from the Internal Revenue Code that may be helpful in determining if a domestic partner qualifies as a dependent for federal purposes. **It is recommended that you seek the advice of your attorney and/or tax consultant prior to completing this affidavit.**

Section 152. DEPENDENT DEFINED.

a. GENERAL DEFINITION – For the purposes of this subtitle, the term "dependent" means any of the following individuals over half of whose support, for the calendar year in which the taxable year of the taxpayer begins, was received from the taxpayer (or is treated under subsection (c) or (e) as received from the taxpayer):

9. An individual (other than an individual who at any time during the taxable year was the spouse, determined without regard to section 7703, of the taxpayer) who, for the taxable year of the taxpayer, has as his principal place of abode the home of the taxpayer and is a member of the taxpayer's household.

b. RULES RELATING TO GENERAL DEFINITION – For purposes of this section –

5. An individual is not a member of the taxpayer's household if at any time during the taxable year of the taxpayer the relationship between such individual and the taxpayer is in violation of local law.

COUNTY OF SUFFOLK

OFFICE OF THE COUNTY COMPTROLLER

In the event that your domestic partner does not qualify as your dependent under IRS Revenue Code 152, the fair market value of the health insurance benefit is treated as income to you for tax purposes. The fair market value of this fringe benefit will be calculated based on the difference between the cost of single and family rates for your coverage. Based on current rates in the EMHP, the amount of imputed income to appropriate members of that Plan would be $1,179.00 per month of coverage, which is $14,148.00 if coverage was maintained for the domestic partner for the entire year. In addition, if applicable, imputed income would also be recognized for any Medicare reimbursements made for a domestic partner who does not qualify as a dependent for tax purposes. The current average reimbursement is $170.10 per month per eligible payer of Medicare Part B reimbursements.

For active employees, imputed income of $544.15 will be added to the taxable wages on your paychecks during the period of coverage; and Federal, NYS and FICA Taxes will be withheld. The amount of the imputed income due to the taxable fringe benefit will be included as Wages on your W-2.

For retirees and employees on leave without pay, you will receive an invoice from the County for $270.58 per quarter for the FICA Tax due on the imputed income from the taxable fringe benefit for each quarter that your domestic partner is covered. You will receive a W-2 for the amount of imputed income resulting from the taxable fringe benefit even if you have no other wages from Suffolk County for the year.

Should you have any questions regarding imputed income, please contact the Suffolk County Department of Audit & Control, Payroll Division, at (631) 853-5050.

It is recommended that you seek the advice of an attorney and/or your tax consultant to determine how enrolling your domestic partner will affect your taxes.

S.C. Department of Human Resources, Personnel and Civil Service
Employee Benefits Unit
P. O. Box 6100, Veterans Memorial Highway
Bldg. #158, William J. Lindsay County Center
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e-mail address: ebu@suffolkcountyny.gov
631-853-4866

TERMINATION OF DOMESTIC PARTNERSHIP OF ENROLLEES OF ANY OF THE SUFFOLK COUNTY PROVIDED HEALTH PLANS

STATE OF: ____________________)
)ss.:
COUNTY OF: ____________________)

I, ______________________________ certify that:
(Name of Enrollee – Please Print)

1. I, ______________________________, and ______________________________
   Name of Enrollee (Please Print) Name of Domestic Partner (Please Print)
   have terminated our domestic partnership.

2. I affirm that the effective date of termination of this domestic partnership is:

   ______________.
   Date

3. I affirm that a copy of this termination statement has been or will be provided to my former domestic partner within seven (7) days.

4. I understand that another Application for Benefits for a Domestic Partner cannot be filed by me until one year after this statement of termination of the previous partnership has been filed with the Suffolk County Department of Civil Service/Human Resources, Employee Benefits Unit.

5. I affirm that assertions in this notice are true to the best of my knowledge and understand that false statements or failure to provide timely notification of the termination of the partnership may require payment by myself of claim amounts incorrectly paid on behalf of my former partner listed above. I understand that false statements may result in disciplinary action by my employer or in other legal actions appropriate to the prosecution of fraud.

Signature of Enrollee (in presence of notary): ______________________________

Social Security Number: ____________________

Date: ________________

Sworn to before me this _____ day of _________, 20__

____
(Notary Public)