

What Documentation Should We Require to Demonstrate Eligibility for Domestic Partner Benefits?

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QUESTION: Our company offers coverage for domestic partners under our self-insured group health plan. What documentation should we require employees to provide to demonstrate eligibility for coverage?

ANSWER: As the sponsor of a self-insured plan, your company is generally free to define the term “domestic partner” as it chooses and to determine what documentation will be required as evidence of the domestic partner relationship. (For insured plans, state insurance law may determine the definition, and the insurer may place conditions on the coverage or require certain documentation.) Some plans require a signed statement or affidavit of partnership by the partners and may require that it be notarized. Other plans require additional documentation, such as proof of financial interdependence (e.g., a joint lease, mortgage, or checking account) or proof of commitment (e.g., being named as each other’s beneficiary on life insurance or retirement plans). Where a state or local domestic partner registry is available, a plan may require proof of registration. Keep in mind that requiring more extensive documentation of domestic partners than is required of married couples may be viewed unfavorably by employees. For purposes of tax treatment of the benefits provided, plans may require an affidavit or similar document indicating whether a domestic partner enrolled for coverage qualifies as a tax dependent and imposing an affirmative obligation on the employee to notify the employer of any changes. A similar requirement may be imposed with respect to other non-spouse beneficiaries who may be eligible under the plan, such as parents, grandparents, or grandchildren.

Most employer-provided health plans that cover spouses require an employee to sign a statement (usually as part of the enrollment form) attesting that the individual being enrolled is the legal spouse. A similar requirement may be imposed for eligible domestic partners. Many plans also require the participant to repay any benefits paid to ineligible individuals. Enrollment of individuals who do not meet the plan’s eligibility criteria can be costly—not only might the plan pay benefits for an individual it did not intend to cover, but the stop-loss insurer may refuse to provide reimbursement for large claims relating to an ineligible individual.

For more information, see EBIA’s Employee Benefits for Domestic Partners at Sections III.C (“Commonly Used Eligibility Criteria for Domestic Partners”) and III.E (“Documentation of Domestic Partner Eligibility”), EBIA’s ERISA Compliance manual at Section IX.K (“Domestic Partner Eligibility”), and EBIA’s Self-Insured Health Plans manual at Section XIV.F (“Verifying Eligibility”). See also EBIA’s Cafeteria Plans manual at Section XI.H (“Providing Health Coverage for Domestic Partners”).

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