



AFFIDAVIT OF DOMESTIC PARTNERSHIP

Each of the undersigned attests that he/she satisfies the definition of Domestic Partnership set forth in the applicable Certificate of Coverage and the provisions in Section I, below, and agrees to the requirements set forth in Section II, below.

I. **Domestic Partnership defined:** may be a relationship between an Employee and one other person of the opposite sex, and in some cases, the same sex. In addition, both persons must meet all of the following requirements:

1. be at least eighteen (18) years of age; and
2. be capable of consenting to the Domestic Partnership; and
3. are not related by blood or a degree of closeness that would prohibit marriage in the law of the state in which the person resides; and
4. are not currently married to, or a Domestic Partner of another person under either statutory or common law; and
5. share the same permanent residence and the common necessities of life; and
6. be financially interdependent and able to furnish the documents listed below in support of such financial interdependence:
 - a. have a single dedicated relationship of at least 6 months duration; and
 - b. have at least two of the following:
 - i. A joint ownership of an automobile;
 - ii. A joint checking, bank or investment account;
 - iii. A joint credit account;
 - iv. A joint ownership or a lease for a residence identifying both partners as tenants; or
 - v. A will and/or life insurance policy which designates the other as primary beneficiary.
7. both the Covered Person and the Domestic Partner must jointly sign the required Affidavit of Domestic Partnership.

II. **Termination of Domestic Partnership:**

The undersigned Employee or partner shall inform the Policyholder of any termination of the Domestic Partnership. The undersigned persons acknowledge that upon the termination of their Domestic Partnership, plan coverage for the Domestic Partner who is not an employee, as well as any dependents of the Domestic Partner, shall cease.

Date: _____

Signature of Employee

Please Print Name

Date: _____

Signature of Domestic Partner of Employee

Please Print Name



III. Employer Certification:

We certify that information to support the requirements of points 1 through 6 above have been provided and this Affidavit of Domestic Partnership has been properly executed by the Covered Person and their Domestic Partner.

Date: _____

Name of Employer

Signature of Employer's Authorized Representative

Printed Name of Employer's Authorized Representative

Please Note: This form, once completed should be kept on file with the Policyholder.