Affidavit of Domestic Partnership

**DECLARATION**

We certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a Domestic Partner of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Domestic Partner’s name Primary Applicant’s name

We certify we meet the following eligibility criteria for establishing Domestic Partnership as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. We have lived together for at least six consecutive months.

2. We are not married to anyone else nor have another Domestic Partner.

3. We are at least 18 years of age and mentally competent to consent to contract.

4. We reside together in the same residence and intend to do so indefinitely.

5. We have an exclusive mutual commitment similar to that of marriage.

6. We are jointly responsible for each other’s common welfare and share financial obligations. We can provide all or some of the types of documentation indicated below if requested.

• Domestic Partner Affidavit

• Joint mortgage or lease

• Designation of Domestic Partner as beneficiary for life insurance and retirement contract

• Designation of Domestic Partner as primary beneficiary in insured’s will

• Durable property and health care powers of attorney

• Joint ownership of motor vehicle, joint checking account or joint credit account

**CHANGE IN DOMESTIC PARTNERSHIP**

We agree to notify the health plan of the termination of our domestic partnership within 30 days. A “Statement of Termination of Domestic Partnership” will be provided to the health plan to affirm that the partnership is terminated.

In the event of termination of the relationship or the death of the primary applicant, the surviving or detached domestic partner may continue membership under this plan, without break in coverage by notifying us within 30 days of the event. We agree that another Affidavit of Domestic Partnership cannot be filed for a minimum of six months.

**ACKNOWLEDGEMENTS**

1. We have provided this information in this Affidavit for the sole purpose of determining our eligibility for Domestic Partnership benefits.

2. We further understand that any false or misleading statements made in order to receive benefits for which we do not qualify may be subject to disciplinary action.

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Primary Applicant’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domestic Partner’s Signature Date