

Affidavit of Domestic Partnership

1. DECLARATIONS: (Please print)

We, _____ and _____ certify that we are
(PRINT NAME OF APPLICANT) (PRINT NAME OF PARTNER)

domestic partners in accordance with the following criteria and eligible for benefits coverage as Domestic Partners under ConnectiCare's Individual HMO/POS (called the "Plan") benefits program.

2. STATUS:

1. We are at least 18 years of age and mentally competent to consent to contract;
2. We are not legally married to each other and neither of us is legally married to any other person;
3. We are not related by blood to any degree that would bar marriage in our state of residence;
4. We have been committed to this relationship for at least 12 months.
5. We reside together in the same residence and have so resided for the last 12 months;
6. We intend to reside together in the same residence indefinitely;
7. We are each other's sole domestic partner and intend to remain so indefinitely;
8. We are jointly responsible for each other's common welfare and financial obligations.

3. PROOF:

We understand that ConnectiCare may require proof of our status as Domestic Partners, including up to three of the following types of documentation, and we are able to provide such documentation:

- Joint ownership or lease of a residence (e.g. home, condominium, etc.) identifying us both either on the deed as co-owners, or on the lease as co-renters;
- Joint ownership of a checking, savings or investment account;
- Joint residence (e.g. copy of driver's license);
- Each other named as the primary beneficiary on any life insurance policy, pension, etc.;
- Each other named as power of attorney for health care decisions;
- Entered into a legally executed contractual agreement accepting responsibility for each other's third party debts.

4. CHANGE IN DOMESTIC PARTNERSHIP:

We agree to notify the Plan if there is any change in our status as domestic partners as attested to in this Affidavit which would make us no longer eligible for benefits. We will notify the Plan within thirty (30) days of such change by filing a Statement of Termination of Domestic Partnership with the Plan. The Statement of Termination of Domestic Partnership shall affirm that the domestic partnership status is terminated as of the date of its execution and that a copy of the Statement has been mailed, postage prepaid, or hand-delivered to the other partner by the party authorizing such action.

5. ACKNOWLEDGMENTS:

1. We acknowledge that any person/company who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us to recover their losses, including attorneys' fees;
2. We have provided the information in this Affidavit for use by the Plan and for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that the information contained in this Affidavit is confidential and will not be released by the Plan unless expressly authorized by either or both of us, or except otherwise required by law, or except as required to providers and insurers of domestic partnership benefits;
3. We acknowledge that our domestic partnership has been entered into voluntarily and willingly;
4. We understand that this Affidavit may create between us certain contractual rights and legal obligations and, that the Plan has encouraged us to seek independent legal advice about those rights and obligations;
5. We affirm, under the penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge.

► _____
Applicant's Signature Date

► _____
Partner's Signature Date

Address: _____

Address: _____
