Blue Cross Blue Shield of Massachusetts

Affidavit of Domestic Partnership Form

Affidavit of Domestic Partnership for Benefits Eligibility

I. Declaration

We, _____ and _____
Employee (print) Domestic Parnter (print)

certify that we are domestic partners in accordance with the following criteria and eligibility for benefits coverage under the _____,
Name of Organization (print)

referred to here as The Organization, benefit program.

II. Status

The employee and intended domestic partner must provide evidence attesting to the following eligibility requirements.

1. We are each other's sole domestic partner and intend to remain so indefinitely.
2. Neither one of us is married to someone else.
3. We are at least eighteen (18) years of age and mentally competent to consent to contract.
4. We are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which we legally reside.
5. We reside together in the same residence, have done so continuously for the past year, and intend to do so indefinitely. Attached to this affidavit as evidence thereof are copies of one or more of the following: driver's licenses showing the same address, canceled rent checks, joint-tenancy lease, jointly held mortgage, passports, or any other document which The Organization may reasonably request which provides evidence of joint residence.
6. We are jointly responsible for each other's common welfare and financial obligations, and attached to this affidavit as evidence thereof are copies of one or more of the following: federal income tax return(s) listing one of us as a dependent of the other, mortgages, leases, titles to real or personal property, joint bank accounts, co-borrowers of loans, beneficiaries on insurance policies, or any other document which The Organization may reasonably request which reflects our joint financial responsibilities.
7. We understand that as domestic partners we are subject to the same 30-day notice requirement as set forth in The Organization's benefit program as are all other employees of The Organization who are covered by or applying for The Organization's benefits.

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Affidavit of Domestic Partnership for Benefits Eligibility (cont.)

III. Change in Domestic Partnership

1. We agree to notify The Organization's benefits administrator if there is any change in our status as domestic partners as attested in the Affidavit which would make us no longer eligible for The Organization's benefits (for example, a change in joint-resident status or if we are no longer each other's sole domestic partner). We will affirm that the domestic partnership status is terminated as of its date of execution and that within 10 days of such notification a copy of the notification has been mailed to the other party by the party authorizing such action.

2. After such termination, I, _____ , understand that
Employee (print)
a subsequent Affidavit of Domestic Partnership cannot be filed until twelve (12) months after notification in writing of the termination has been filed with The Organization's benefits department.

3. We have provided the information in this affidavit for use by The Organization's benefit administrator for the sole purpose of determining our eligibility for domestic partner benefits and understand that the information will be held strictly confidential.

4. We understand that premiums or parts of premiums for individual coverage may be included in the employee's reported gross income for tax purposes.

5. We understand that some courts have recognized non-marriage relationships as the equivalence of marriage for the purpose of establishing and dividing community property.

6. We understand that domestic partners and their eligible dependents are eligible for COBRA continuation rights for health insurance.

7. We affirm, under the penalty of perjury, that the assertions in this affidavit are true to the best of our knowledge.

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IV. The Organization's Rights

1. The Organization reserves the right to terminate, modify, or adjust this policy at any time and in its sole discretion.

Employee Signature _____ Date _____

Domestic Partner Signature _____ Date _____

Domestic Partner Address _____

INTERNAL USE ONLY:

I acknowledge receipt of this affidavit. *(Please send a copy of this document and supporting documents to Blue Cross Blue Shield with enrollment form and please keep originals for your records.)*

Business Office (print) _____

Business Officer Signature _____ Date _____

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Statement of Termination of Domestic Partnership

This statement is intended for the sole purpose of determining eligibility for domestic partnership benefits at _____ , referred to here as The Organization.

When this statement is received in the Business Office or Benefits Administrator of The Organization, benefits will be discontinued on the last day of the month that the statement is received, or on a date consistent with existing policies and procedures.

I, _____ , certify that the following is accurate:

1. _____ and I are no longer domestic partners as defined in the Affidavit of Domestic Partnership filed by me with The Organization on _____.
   Date (print)
2. I am filing this Statement of Termination in order to cancel the abovementioned Affidavit of Domestic Partnership.
3. I am mailing my former partner a copy of this notice at:

   _____

   _____
   Former Partner's Address (print)

   _____
   Date Mailed (print)

I declare that the above statements are true and correct.

Signed: _____

Print Name: _____

Address: _____

_____

Date: _____

INTERNAL USE ONLY:

_____

Business Officer or Benefits Administrator Acceptance Date

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