

## DOMESTIC PARTNER AFFIDAVIT

(Fill out Completely)

Subscriber's name	
Subscriber's social security number_	
Date	
affidavit is required at the time of enr Healthcare with your completed enro released for any purpose other than to unless Patriot Healthcare has your ex submitting this affidavit, each party a	mestic Partners and their eligible children, the following completed ollment. This affidavit must be notarized and submitted to Patriot Ilment form. The information in this affidavit will not be used or establish eligibility and availability of Benefits or as required by law pressed written consent for other use or release. By signing and grees to the terms of the affidavit and to the terms and conditions of cate, including the Domestic Partners Rider.
We,	and
Applicant (print)	Domestic Partner (print)

certify under penalty of perjury, that each and every statement contained in this affidavit is true and correct to the best of our knowledge. We agree to all of the terms of this affidavit and declare the following:

# I. Declaration of Fact:

- **A.** We are adults and neither of us is legally married. We have resided together in the same legal residence for at least 24 consecutive months as each other's sole domestic partner. We live in a committed, mutually monogamous, nonplatonic family-type relationship and intend to remain so indefinitely.
- **B.** It has been at least 24 months since either of us has filed a Statement of Termination naming the other as a party or naming another partner.
- C. It has been at least 24 months since either of us has been a party to a divorce or annulment proceeding.
- **D.** Neither of us is the policy holder in a health benefits plan which covers a spouse, ex-spouse or former domestic partner as a dependent. Neither of us is a dependent on any other person's health plan policy.
- **E.** We are at least 18 years of age and mentally competent to enter into contracts and are each jointly responsible for the common welfare and financial obligations of the other.
- **F.** We are not related by blood closer than would preclude lawful marriage in the state where we are legal residents.
- **G.** The Subscriber's enrollment form is complete and contains all of the information required by Patriot Healthcare regarding the identity and residence of eligible persons and contains information about any other health insurance coverage available to the Subscriber, Domestic Partner and any eligible children covered under the Subscriber's policy, including children of the Domestic Partner.

## II. Change in Domestic Partnership:

**A.** Each of us agrees to notify Patriot Healthcare of any changes to our domestic partnership, as attested to in the declarations above. For example, if one partner changes residence or if we are no longer each other's sole domestic partner, we will notify Patriot Healthcare. Notice will be in the form of a Statement of Termination, which will be completed in full and will include the names of any children affected by the change. The Statement of Termination will be filed with Patriot Healthcare within 30 days of the change. Coverage for the Domestic Partner and any effected children will end on a date as determined by Patriot Healthcare.

**B.** Both partners agree that if either executes a Statement of Termination, he or she will mail a copy of the Statement of Termination to the last known address of the other (unless the other party is deceased).

C. Both partners agree that a subsequent Domestic Partner Affidavit cannot be filed until 24 months after any Statement of Termination is received by Patriot Healthcare. The 24 month period will be waived only if another Domestic Partner Affidavit is filed for the same domestic partners within 31 days following the date that the Statement of Termination is received by Patriot Healthcare. By signing this Affidavit, we agree that Patriot Healthcare has full recovery rights if it is determined that any statement is false or misleading Patriot Healthcare's recovery rights are described in Patriot Healthcare's Subscriber Certificate of Group Health Benefits. We also agree that if any statement is determined to be false or misleading, or if we fail to notify Patriot Healthcare of changes effecting eligibility, our health coverage may be terminated on a date as determined by Patriot Healthcare.

date	
date	
of in the year ed the foregoing, and swore to its truth.	before me
gnature and Commission Exp. Date	
	date  of in the year ed the foregoing, and swore to its truth.

Form 005a Rev (3/05)

#### FOR PATRIOT USE ONLY

Suggested documentation to be requested of domestic partners for submission with affidavit:

#### Illustrates common residence:

- 1. joint lease or mortgage
- 2. valid driver or non-driver photo ID
- 3. recent utility bill (telephone, cable TV, gas/electricity)
- 4. recent bank account/credit card statement
- 5. pervious year's state resident income tax filing
- 6. recent state jury duty attendance certificate
- 7. recently issued voter registration card
- 8. recent rent bill or receipt

### Illustrates financial interdependence:

- 1. joint lease or mortgage
- 2. joint checking, savings, or brokerage account
- 3. joint automobile registration
- 4. joint ownership of a major asset
- 5. designation of domestic partner as beneficiary in a will
- 6. designation of domestic partner as beneficiary for life insurance or pension retirement benefits
- 7. durable power of attorney