# AFFIDAVIT OF DOMESTIC PARTNERSHIP

BlueCross BlueShield of Oklahoma

## DECLARATION

We certify that _____ is a Domestic Partner of

Domestic Partner's name (please print)

_____ in accordance with the following eligibility criteria.

Employee's name (please print)

1. We have lived together for at least six months prior to enrollment in the plan.
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.
7. We can provide all or some of the types of documentation indicated below if requested.

- Domestic Partner Affidavit
- Designation of Domestic Partner as beneficiary for life insurance and retirement contract
- Designation of Domestic Partner as primary beneficiary in employee's or insured's will.
- Durable property and health care powers of attorney.
- Joint ownership of motor vehicle, joint checking account or joint credit account.
- Joint mortgage or lease

## CHANGE IN DOMESTIC PARTNERSHIP

We agree to notify the Group within thirty (30) days of any change in Domestic Partnership status which would make the Domestic Partner no longer eligible for benefits (e.g., a change in joint residency,) by filing a Statement of Termination of Domestic Partnership. The Statement of Termination shall affirm that the Domestic Partnership status is terminated as of the date of execution specified therein and that a copy has been mailed to the other party by the party authorizing the action.

Upon termination of this Affidavit of Domestic Partnership (evidenced by a Statement of Termination of the Partnership signed by the Insured), I _____ 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 subject the Employee/Insured to disciplinary action.

Employee Signature _____ Date _____

Employee Social Security Number _____ EMPLID_____

Employee/Domestic Partner Home Address _____

Domestic Partner Signature _____ Date _____

On this _____ day of _____, 20____, before me personally came _____ and _____, to me known to be the individual described as "Employee/Insured" and the individual described as Domestic Partner in the above document entitled "AFFIDAVIT OF DOMESTIC PARTNERSHIP" and who executed same as a free and voluntary act for the uses and purposes stated herein.

_____
Witness (excluding involved parties)