



# Regence

Regence BlueCross BlueShield of Oregon and Regence Life and Health Insurance Company are Independent Licensees of the Blue Cross and Blue Shield Association

**Please return the completed form.**

By Mail: PO Box 1271 MS5C  
Portland, OR 97207-1271  
By Fax: 1 (866) 303-5117

## AFFIDAVIT OF DOMESTIC PARTNERSHIP

### SECTION ONE

I, \_\_\_\_\_ and \_\_\_\_\_ are domestic partners and we  
(Name) (Name of Domestic Partner)

1. are each 18 years of age or older;
2. share a close personal relationship and are responsible for each other's common welfare;
3. are each other's sole domestic partner;
4. are not legally married to anyone nor have had another domestic partner within the previous 30 days;
5. are of the (choose one)  same sex  opposite sex. Check your benefits booklet to see if domestic partner coverage is limited to the same or opposite sex;
6. are not related by blood closer than would bar marriage in the state issuing the contract;
7. share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
8. are jointly financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and medical expenses. **Note:** Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost; and
9. were mentally competent to contract when our domestic partnership began.

### SECTION TWO

1. I understand that my domestic partner is eligible for enrollment only:
  - a) during the first 31 days (or the amount of time allowed under my group's contract) following the date on which the domestic partnership is established and upon receipt of this properly executed Affidavit (by "established," we mean the date on which the qualifying conditions under Section One of this Affidavit were met \_\_\_\_\_); or  
(Date of Establishment)
  - b) based on the late enrollment provisions of my group's contract if my domestic partner did not enroll when initially eligible and upon receipt of this properly executed Affidavit.
2. I understand further that children of my domestic partner are eligible if they meet the dependent eligibility requirements of my group health plan.
3. I understand coverage for my domestic partner shall terminate upon a change in circumstance attested to in Section One of this Affidavit.
4. I agree to provide a "Statement of Termination of Domestic Partnership" to my payroll/personnel representative within 31 days if there is any change in circumstances attested to in this Affidavit.
5. After such termination, I understand an application to add a new domestic partner cannot be filed earlier than 30 days from the filing of a Statement of Termination of Domestic Partnership with my payroll/personnel representative.

**SECTION THREE**

1. We understand the information contained in this Affidavit will be held confidential and is subject to disclosure only upon express written authorization or as required by law.
2. We understand a civil action may be brought against us for any losses, including reasonable attorney fees and court costs because of a willful falsification of information contained in this Affidavit of Domestic Partnership.
3. We understand under applicable federal and state income tax law, payments for health coverage of a domestic partner may not be eligible under Section 125 Plan (if available through that group) and that coverage of the non-employee domestic partner could result in additional taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes).
4. We understand, in addition to the contract eligibility requirements of my group for domestic partner coverage, there are terms and conditions of coverage set forth in the group Contract of each health care plan offered through my group to which we agree to be bound.
5. We understand willful falsification of information contained in this Affidavit may result in our termination from enrollment under the health care plan which we select.
6. We also certify under penalty of perjury under the laws of the state issuing the contract that the foregoing is true and accurate to the best of our knowledge.

▶ \_\_\_\_\_  
Signature of Employee

▶ \_\_\_\_\_  
Signature of Domestic Partner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_