

Affidavit for domestic partner benefits



For same gender partners

Eligibility

You may enroll as a Covered Dependent if you are the Domestic Partner of the Subscriber, as defined by and under conditions allowed by the employer. A Domestic Partner is an individual who lives with the Subscriber in a Domestic Partnership. A Domestic Partnership is defined as:

- Two individuals of the same gender who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment similar to that of marriage;
- A relationship in which the partners have agreed to be responsible for each other's welfare; and
- The partners are financially interdependent.
- Additionally, the subscriber must comply with the eligibility requirements that are required by the group and outlined in the agreement between the Group and Priority Health.

Enrollment

SECTION 4 of your Group's Certificate, "ENROLLMENT" defines when a Domestic Partner is eligible to enroll for coverage. Section 4.B(1) "Special Enrollment of Newly Eligible Employees and Dependents" is amended by adding the following language to the end of the first paragraph: Domestic Partners of eligible employees are not eligible to enroll under this Section 4.B(1).

"Continuation, Conversion OR Extension of Benefits" does not apply to Domestic Partners. The only persons eligible for COBRA coverage are the spouse and the dependent children of a Subscriber. Domestic Partners are not eligible for COBRA coverage. Domestic Partners are entitled to conversion coverage as described in Section 13.B.

Dependents of the Subscriber and/or the Subscriber's Domestic Partner, who are financially dependent upon the Domestic Partner, are eligible for coverage subject to all of the terms and conditions of the Certificate, this rider and any other riders attached to this Certificate.

We, _____ and _____, have read and understand the above, we affirm all of the following:

1. We are the sole, same-sex domestic partners of the other;
2. We are 18 years of age or older;
3. Neither of us legally married;
4. We are not related by blood in manner that would bar legal marriage if we were not of the same or opposite gender;
5. We have lived together at the same regular and permanent residence for a minimum of 6 consecutive months and submit this affidavit as proof. We agree to provide the group and/or Priority Health additional written proof that we meet this residency requirement, if required to do so, and understand that a failure to provide such proof could result in loss of coverage;
6. We are financially interdependent;
7. If, at any time, we terminate our domestic partnership or if any of the above statements cease to be true, we agree to notify our employer and Priority Health with 30 days of termination;
8. We understand that we may not file another affidavit for domestic partnership benefits for at least 12 months after termination of this domestic partnership; and
9. We agree to reimburse the employer and Priority Health for cost of providing benefits if the domestic partner is not eligible under the employer's definitions.

Date: _____

Employee Signature _____

Subscribed and sworn to before me this ____ day of _____, 20____

Notary Public, _____ County in Michigan

My Commission Expires: _____

Domestic Partner Signature _____

Subscribed and sworn to before me this ____ day of _____, 20____

Notary Public, _____ County in Michigan

My Commission Expires: _____