AFFIDAVIT OF DOMESTIC PARTNERSHIP

Group Name_____
Group No_____
Social Security No_____

State of Oregon, County of _____

I, and _____ are domestic partners and meet the requirements set forth below in each and every respect.

1. We are each 18 years of age or older.
2. We share a close personal relationship.
3. We are responsible for each other's common welfare.
4. We share a permanent residence with the intent to continue doing so indefinitely.
5. We are jointly financially responsible for basic living expenses including, but not limited to, food, shelter, and medical expenses.
6. Neither of us is married to anyone else.
7. We have lived together as a domestic partnership for a minimum of six months and have met all requirements set forth herein for six months or more.
8. We are not related by blood closer than would bar legal marriage in Oregon and any other state where we have a permanent residence and are domiciled.
9. We were mentally competent to consent to contract when our domestic partnership began and remain mentally competent.
10. We are each other's sole domestic partner and have been for at least six months prior to the date of this affidavit.
11. We agree that we are bound by and subject to all the provisions of the health plan and any additional provisions of the domestic partnership endorsement.
12. We understand that willful falsification of information contained in this affidavit may result in the termination of our enrollment in the health plan and could result in a claim for damages for losses sustained by the health plan because of such willful falsification.
13. We understand that any coverage obtained by reason of this affidavit will terminate if we fail to meet any of the requirements of this affidavit as well as any applicable requirements of the underlying health plan and the domestic partnership endorsement.
14. We agree to notify the health plan policyholder in writing within 31 days of any change, which would cause us to fail to meet any requirement of this affidavit, the underlying health plan, or the domestic partnership endorsement.
15. We certify under penalty of perjury under the laws of the State of Oregon or of any other state where this affidavit is executed that the foregoing is true and accurate to the best of our knowledge.

_____
Employee's signature

Date: _____

_____
Domestic partner's signature

Date: _____