BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Declaration of Domestic Partnership

I. Declaration

We, _____ and _____, each
print or type employee name *print or type name of domestic partner*

certify and declare that we are domestic partners meeting **all** of the following requirements:

a. We currently reside together in an exclusive mutual commitment similar to marriage, have done so for at least the last 12 consecutive months, and intend to continue the relationship indefinitely;

b. We are not married to each other or any other individual (statutory or common law), and neither of us is a member of another domestic relationship;

c. We are both at least 18 years of age;

d. We are not related by blood or a degree of closeness that would prohibit marriage under the laws of your state;

e. Each of us is the other's sole domestic partner and is responsible for the other's common welfare;

f. We were both mentally competent to consent to contract when the domestic partnership began and remain so for purposes of contracting for domestic partner health insurance coverage or the dependent life insurance benefit;

g. We are financially interdependent, jointly responsible for the other's basic living expenses, and able to provide documentation showing at least three of the following to demonstrate that such interdependence has existed for a minimum of the last 12 consecutive months:

1. Joint mortgage, joint property tax identification or joint tenancy on a residential lease;
2. Joint bank, investment or credit account;
3. Joint liabilities (e.g., credit cards, car loans);
4. Joint ownership of real property or a common leasehold, interest in real property, such as a residence or business, or common ownership of personal property such as an automobile;
5. A Will or testamentary device designating the other as the primary beneficiary or a beneficiary designation form currently in effect for a retirement plan or life insurance policy setting forth that one partner is a beneficiary of the other;

6. Designation of one partner as holding power of attorney for health care or durable property for the other; and/or
7. Written agreement(s) or contract(s) regarding your relationship showing mutual support obligations.

II. Change in Domestic Partnership

We understand and agree that we have an obligation to notify Blue Cross Blue Shield of Arizona, Inc., in writing, if any of the criteria specified in paragraphs (a) through (g) above are no longer met, or if the documentation provided pursuant to paragraph (g) as evidence of the domestic partnership, has been superseded or invalidated . Examples of changes that could affect eligibility for coverage of one or more of the domestic partners and any eligible children include:

a. Termination of the domestic partnership through death or dissolution;
b. A change in the residence of one of the domestic partners ;
c. A change in the financial interdependence as described above; or
d. Loss of employment of the eligible employee.

III. Dependent Children of the Domestic Partner

(Section III applies to health insurance coverage only.)

We understand and agree that the following dependent child(ren) _____
print or type name(s) of child(ren) of

_____ of _____
domestic partner *print or type name of domestic partner*

is (are) eligible for coverage if the child(ren) meet(s) the following criteria:

- Satisfy the criteria listed in the benefit plan for coverage of dependents;
- Is/Are under 26 years of age; and
- If a child is over age 18, the child is not eligible for coverage provided by the child's own employer.[1]

IV. Acknowledgments

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in the Declaration or for failure to notify Blue Cross Blue Shield of Arizona, Inc. of changed circumstances as required above. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify Blue Cross Blue Shield of Arizona, Inc. of changed circumstances affecting eligibility for coverage for my domestic partner and their children may lead to disciplinary action against me, including discharge from employment.

2. We have provided the information in this Declaration for use by Blue Cross Blue Shield of Arizona for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand that the information provided in this Declaration will be treated as confidential by

[1] This can apply only to a grandfathered plan and only until that plan's renewal on or after January 1, 2014.

Blue Cross Blue Shield of Arizona, Inc. but will be subject to disclosure: a) upon the express written authorization of one or both of the undersigned; b) upon request of the insurer or plan administrator; or c) if otherwise required by law.

3. We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.

4. We understand and agree that Blue Cross Blue Shield of Arizona, Inc. will send Explanation of Benefits for medical services received to the employee for all covered members under the insurance contract and that such Explanation of Benefits may contain personal, private and confidential information. *(Applies to health insurance coverage only.)*

We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

EMPLOYEE **DOMESTIC PARTNER**

(Last)	(First)	(MI)	(Last)	(First)	(MI)
Signature		Date	Signature		Date
Social Security Number			Social Security Number		
Common Residence Address			City	State	Zip Code
Mailing Address			City	State	Zip Code

State of Arizona)
ss.)
County of _____)

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20____,

by _____ and _____.

_____
Notary Public

My Commission Expires: _____