BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

STATEMENT OF DOMESTIC PARTNERSHIP

Note to Group: Keep a copy of this document for your records and forward the original Statement attached to an appropriate Group Application and Change Form.

Group

Number _____

Name _____

Employee

Name _____ **Identification #** _____

Home Address _____ **Social Security #** _____

_____ **Birth Date** _____

Domestic Partner

Name _____ **Social Security #** _____

Home Address _____ **Birth Date** _____

_____

We the undersigned attest to the following:

- each party is the sole domestic partner of the other;
- each party is at least eighteen (18) years of age or older and competent to enter into a contract in the state in which he or she resides;
- both parties currently share a common legal residence and have shared said residence for at least six (6) months prior to application for domestic partner coverage;
- neither party is married, a party to a Civil Union, or related to the other by adoption or blood to a degree of closeness that would bar marriage/Civil Union in the state in which they legally reside;
- both parties are in a relationship of mutual support,caring, and commitment and intend to remain in such a relationship in the indefinite future;
- the parties are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household; the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

SWORN STATEMENT

We declare that all the foregoing information provided by us is true and correct and that all provisions of this Statement have been met.

We understand that:

- any entities or persons (including, but not limited to, Blue Cross and Blue Shield of Vermont) who suffer any loss because of any false statements contained in this Statement may bring a civil action suit against us to recover their respective losses, including reasonable attorney's fees;
- if there is any change in the information certified in the Statement of Domestic Partnership that would make the domestic partner ineligible, the employee must complete and file a Termination of Domestic Partnership form within 30 days of the changes; and

- the effective date of coverage for the domestic partner and any initially eligible dependents of the domestic partner is:
  - on the open enrollment date if Blue Cross and Blue Shield of Vermont receives the Statement of Domestic Partnership and application form before your group open enrollment date; or
  - the first of the month following the group open enrollment date if Blue Cross and Blue Shield of Vermont receives the Statement of Domestic Partnership and application form during the month in which the group's open enrollment date occurs.

We agree to notify the employer if our domestic partnership no longer meets the criteria established herein.

_____ _____

Employee Signature ***Domestic Partner Signature***

STATE OF _____

COUNTY OF _____

On this _____ day of _____ ,20 ____ before me personally appeared

_____ and _____ , to me

known to be the persons described herein, and who executed the foregoing, and swore to its truth.

Before me, _____

Notary Public Signature and Commission Exp. Date

ATTACHMENTS

If required, attached to this document is the following documentation in support of this Statement of Domestic Partnership:

- proof of common residence—e.g.,driver's licenses showing same address, passports or designations for receipt of mail; and
- proof of financial interdependence—e.g., joint checking, savings or credit card statements, executed powers of attorney, insurance policies, and/or copies of designated signatures on safety deposit boxes.