HealthTrust

DOMESTIC PARTNER AFFIDAVIT

PLEASE COMPLETE AND RETURN THIS FORM TO YOUR EMPLOYER

Enrollee Name: _____ **Date:** _____

Enrollee Mailing Address: _____ **Date of Birth:** _____

Group Name: _____

As a condition of membership for Domestic Partners and their eligible children, the following completed affidavit is required at the time of enrollment. *This affidavit must be notarized and submitted to your Group Benefits Administrator with your completed enrollment form*. Your Group will forward a copy of the affidavit and enrollment form to HealthTrust. The information in this affidavit will not be used or released for any purpose other than to establish eligibility and availability of benefits or as required by law, unless your Group or HealthTrust have your expressed written consent for other use or release. By signing and submitting this affidavit, each party agrees to the terms of the affidavit and to the terms and conditions of coverage under the Subscriber Certificate and/or Dental Plan Description, including the Domestic Partners Rider.

We, _____ and _____
(Enrollee Print Name) (Domestic Partner Print Name)

Certify under penalty of perjury, that each and every statement contained in this affidavit is true and correct to the best of our knowledge. We agree to all of the terms of this affidavit and declare the following:

Declaration of Fact:

1. We are adults and neither of us are legally married. We have resided together in the same legal residence for at least 12 consecutive months or length of time over the 12 months the group has elected as each other's sole Domestic Partner. We live in a committed, mutually monogamous, non-platonic family-type relationship and intend to remain so indefinitely. We are competent to enter into contracts. We are jointly responsible for the common welfare and financial obligations of the relationship.
2. It has been at least 12 months since either of us has filed a Statement of Termination naming the other as a party or naming another partner.
3. It has been at least 12 months since either of us has been a party to a divorce or annulment proceeding.
4. Neither of us is the policy holder in a health and/or dental benefits plan which covers a spouse, ex-spouse or former Domestic Partner as a dependent. Neither of us is a dependent on any other person's health and/or dental plan policy.
5. We are at least 18 years of age and mentally competent to enter into contracts and are each jointly responsible for the common welfare and financial obligations of the couple.
6. We are not related by blood, which would bar marriage in the state where we are legal residents.
7. The Subscriber's enrollment form is complete and contains all of the information required by the Group and by HealthTrust regarding the identity and residence of eligible persons and contains information about any other health and/or dental insurance coverage available to the Subscriber, Domestic Partner and any eligible children covered under the Subscriber's policy, including children of the Domestic Partner.

Change in Domestic Partnership:

Each of us agrees to notify the Group of any changes to our domestic partnership, as attested to in the declarations above. For example, if one partner changes residence or if we are no longer each other's sole Domestic Partner, we will notify the Group. *Notice will be in the form of a Statement of Termination, which will be completed in full and will include the names of any children effected by the change*. The Statement of Termination will be filed with the Group within 31 days of the change. Coverage for the Domestic Partner and any affected children will terminate at the end of the month, which includes the date on which the individual ceases to meet the definition of a Domestic Partner. Continuation and conversion privileges will be subject to the terms of the Domestic Partners Rider and the Subscriber Certificate and/or Dental Plan Description.

Both partners agree that if either executes a Statement of Termination, he or she will mail a copy of the Statement of Termination to the last known address of the other (unless the other party is deceased).

Both partners agree that a subsequent Domestic Partner Affidavit cannot be filed until 12 months after any Statement of Termination is received by the Group. The 12 month period will be waived only if another Domestic Partner Affidavit is filed for the same domestic partners within 31 days following the date that the Statement of Termination is received by the Group.

By signing this affidavit, we agree that HealthTrust has full recovery rights if it is determined that any statement is false or misleading. We also agree that if any statement is determined to be false or misleading, or if we fail to notify the Group of changes effecting eligibility, our health and/or dental coverage may be terminated on a date as determined by HealthTrust.

_____

Enrollee Signature Date

_____

Domestic Partner Signature Date

NOTARY PUBLIC STATEMENT

STATE OF _____

COUNTY OF _____

on this _____ DAY OF _____, in the year _____,

before me personally appeared herein and who executed the foregoing, and swore to its truth.

Before me, _____

Notary Public Signature and Commission Exp. Date