Blue Shield of California
An Independent Member of the Blue Shield Association

# Affidavit of Domestic Partnership

To enroll or delete your Domestic Partner in your health plan, you must complete this form and submit it along with your Enrollment Application to your employer. Please note that if you have previously filed a Declaration of Domestic Partnership with the State of California (California State Family Code Section 297), you may submit a copy of the Declaration of Domestic Partner in lieu of submitting this form.

**Submit the Affidavit of Domestic Partnership form during open enrollment or within 31 days of establishing or terminating your Domestic Partnership.**

**Instructions:** *Complete the information below, sign and date the form. Please return the completed form to your employer.*

Employee Name ______________________ Social Security Number ______________

Address ______________________________________________

City ______________________________ State __________ Zip __________

Domestic Partner Name ______________________________________

## Establishment of Domestic Partnership:

- ❑ I share the same principal residence with my partner and we have an intimate and committed relationship of mutual caring.
- ❑ My partner and I are responsible for each other's basic living expenses during the domestic partnership and share financial responsibility for any debts incurred as a direct result of Blue Shield of California's extension of benefits. Anyone who is owed these expenses can collect from either of us.
- ❑ My partner and I are not so closely related by blood that legal marriage or a registered domestic partnership would otherwise be prohibited.
- ❑ My partner and I are both 18 years of age or older, and neither partner is currently married.
- ❑ Neither of us has a different domestic partner now; and neither of us has had a different domestic partner within the last six months (this condition does not apply if you had a partner who died).

I declare that all the above statements are true and correct and contain no material omissions of fact to the best of our knowledge and belief. I will notify Blue Shield of California within 31 days if I am no longer in a domestic partnership. I understand that all domestic partnership benefits will end if I am no longer in a domestic partnership.

Employee Signature ______________________________ Date __________

Partner's Signature ______________________________ Date __________

- ❑ I have provided a copy of this form to my domestic partner.

## Dissolution of a Domestic Partnership:

- ❑ I am no longer in a domestic partner relationship.

If termination is caused by death or marriage of your domestic partner please indicate the date of death or the marriage: __________ .
(month / day / year)

I declare that the above statement is true regarding the dissolution of my domestic partnership.

Employee Signature ______________________________ Date __________

- ❑ I have provided a copy of this form to my former domestic partner.