Excellus
165 Court Street
Rochester, NY 14647

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AFFIDAVIT OF DOMESTIC PARTNERSHIP-GROUP

Group Name: _____

Group Number: _____

I. Domestic Partner Certification

We, _____ (Employee) and _____ (Domestic Partner) certify that we are domestic partners in accordance with the following criteria and eligible for enrollment under my employer's Certificate of Coverage:

A. Definition of Domestic Partner

We meet the following criteria, as required for Domestic Partners, under the Certificate of Coverage issued by Excellus Health Plan, Inc.:

1. We do not have any other domestic partners now and understand that we may not have any other domestic partners during the period our coverage is in effect, and
2. We are eighteen (18) years of age or older, mentally competent to contract, unmarried and unrelated by marriage or blood in a way that would bar marriage, and
3. We reside together in a committed relationship and have been each other's sole domestic partner for six (6) months or more, and
4. We are economically interdependent upon each other
5. We did not enter into this relationship solely for the purposes of obtaining benefits.

B. Economic Interdependence

We are economically interdependent upon each other, as shown by one (1) of the items checked below:

☐ Registration as the member's domestic partner, if living in a city or county providing for registration as domestic partners (please attach), or

☐ Completion of this affidavit to confirm an existing and established relationship of intended future duration that involves economic interdependency

C. Proof of Cohabitation

We have attached proof of cohabitation, such as a driver's license for both parties, tax returns, or other proof, which demonstrate that we live together. Proof used in this section may not be used in another section. Please list the item(s) attached and explain relevance: _____

_____

D. Other Proof of Domestic Partnership

We have checked the at least two (2) boxes below and attached the supporting documentation.

- ☐ A joint bank account
- ☐ A joint credit or charge card
- ☐ A joint obligation on a loan
- ☐ Status as authorized signatory on the partner's bank account, credit or charge card
- ☐ Joint ownership or holding of investments
- ☐ Joint ownership of residence
- ☐ Joint ownership of real estate other than residence
- ☐ Listing of both partners as tenants on the lease of the shared residence
- ☐ Shared rental payments of residence, which need not be shared 50/50
- ☐ Listing of both partners as tenants on a lease, or shared rental payments, for property other than the residence
- ☐ A common household and shared household expense (e.g., grocery bills, utility bills, telephone bills) which need not be shared 50/50
- ☐ Shared household budget for purposes of receiving government benefits
- ☐ Status of one as representative payee for the other's government benefits
- ☐ Joint ownership of major items of personal property (e.g., appliances, furniture)
- ☐ Joint ownership of a motor vehicle
- ☐ Joint responsibility for child-care (e.g., school documents, guardianship)
- ☐ Shared child-care expenses (e.g., babysitting, daycare, school bills), which need not be shared 50/50
- ☐ Execution of wills naming each other as executor or beneficiary
- ☐ Designation as beneficiary under the other's retirement benefits account
- ☐ Mutual grant of durable power of attorney
- ☐ Affidavit by creditor or other individual able to testify to partners' financial interdependence
- ☐ Other item(s) of proof, sufficient to establish economic interdependency under the circumstances of this case. Please list the item(s) attached and explain the relevance of the item(s): _____

E. Eligibility of Dependents

We understand that domestic partners and dependents are subject to all of the other eligibility provisions of the benefit plan, such as limitations regarding age of dependents and students.

F. Termination of Domestic Partnership

We understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in a circumstance attested to in this affidavit.

We agree to provide written notice to my payroll/personnel representative if there is any change of circumstances attested to in this affidavit within thirty (30) days of the change by filing a statement of Termination of Domestic Partnership.

G. Continuation of Coverage After Termination

We understand that neither my Domestic Partner nor any covered dependents are eligible for continuation of benefits under COBRA.

H. Effective Date of Coverage

We understand that Excellus Health Plan, Inc. determines, in its sole judgment, whether or not a domestic partnership exists. Excellus Health Plan, Inc., will make the determination based upon this signed affidavit, the attached documentation and the completed change of coverage form. We understand that if Excellus Health Plan, Inc. determines a domestic partnership exists, my Domestic Partner and his/her eligible dependent(s) will be covered under the Certificate or Group Health Plan, as follows:

1. My Domestic Partner and eligible dependents will be covered as long as we have provided Excellus Health Plan, Inc., the signed affidavit, all required documentation necessary to establish the domestic partnership and the completed change of coverage form within thirty (30) days of a qualifying event.
2. If we do not provide Excellus Health Plan, Inc. with the all information required above, within thirty (30) days of a qualifying event, the coverage for my Domestic Partner and his/her eligible dependents will not be effective until the next open enrollment date.

We certify, under penalty of perjury, that the foregoing is true and correct.

We understand that falsification of information contained in this Affidavit may lead to disciplinary action, up to and including immediate termination of the Employee's employment.

We also understand that falsification of information contained in this Affidavit may subject us to civil action to recover any losses, including reasonable attorney's fees incurred by Group or by Excellus Health Plan, Inc., for benefits provided.

Employee:

State of _____

County of _____

I, _____do hereby under oath depose and say that the forgoing representations, information and documentation provided herein are true, correct and complete.

_____ _____

Employee Signature Date

_____

Employee Printed Name

III. Dependent Child Certification:

I certify that my Domestic Partner's child or children named below meet the following requirements:

1. A parent-child relationship exists between the child or children and me.
2. The child is, or children are, primarily dependent upon me for at least 50% of his/her/their support.
3. The child is, or children are, unmarried, reside in my household and meet the age eligibility requirements for the policy purchased by _____ (Group Name).
4. I assume full responsibility and control, including any debts incurred by the child or children.
5. I, or my Partner, have a court-appointed legal relationship with the child(ren) (i.e., adoption, guardianship, foster child), or my Partner is the biological parent of the each child listed below.

Last Name	First Name	MI	Birth Date

I understand that falsely certifying a dependent's eligibility or failure to inform my employer when a dependent no longer meets applicable eligibility requirements may result in disciplinary action, up to and including immediate termination of employment.

Employee Signature _____ Date _____

Employee Printed Name _____

Approved: _____
Group Name

Authorized Group Representative Signature _____ Date _____

Group Representative Name Printed _____ Title _____