IDAHO AGC HEALTH PLAN

Declaration of Domestic Partnership Affidavit*

****Read Before Signing****

We certify that _____ is a Domestic Partner of _____
Domestic Partner's name (please print) Employee's name (please print)

in accordance with the following eligibility criteria. We certify we met the following eligibility criteria for establishing a Domestic Partnership as of _____.
Date

1. We have lived together for at least six months.
2. We are not married to anyone else nor have another Domestic Partner.
3. We are at least 18 years of age and mentally competent to consent to contract.
4. We reside together in the same residence and intend to do so indefinitely.
5. We have an exclusive mutual commitment similar to that of marriage and understand that a dissolution of the domestic partnership may require steps similar to a divorce.
6. We are jointly responsible for each other's common welfare and share financial obligations.
7. We are providing at least two types of documentation indicated below with this affidavit.
   - Domestic Partner Affidavit
   - Joint mortgage or lease
   - Designation of Domestic Partner as beneficiary for life insurance and retirement contract
   - Designation of Domestic Partner as primary beneficiary in employee's or insured's will.
   - Durable property and health care powers of attorney
   - Joint ownership of motor vehicle, joint checking account or joint credit account

TERMINATING A DOMESTIC PARTNERSHIP

We agree to notify the Idaho AGC Health Plan within thirty (30) days of any change in Domestic Partnership status that would make the Domestic Partner no longer eligible for benefits (e.g., a change in joint residency,) by filing a Statement of Termination of Domestic Partnership and registering the termination of the domestic partnership with my state or city of residence, if applicable. The Statement of Termination shall affirm that the Domestic Partnership status terminated as of the date of execution specified therein and that a copy has been mailed to the other party by the party authorizing the action. Upon termination of this Affidavit of Domestic Partnership (evidenced by a Statement of Termination of Domestic Partnership, signed by the Insured), I agree that another Affidavit of Domestic Partnership cannot be filed for a minimum of twelve months.

ACKNOWLEDGEMENTS

1. We have provided true and accurate information in this Affidavit for the sole purpose of determining our eligibility for Domestic Partnership benefits.
2. We further understand that any false or misleading statements made in order to receive benefits for which we do not qualify may result in denial of payment for claims and full reimbursement to the Idaho AGC Health Plan for any claims paid.

_____
Employee Signature Date

_____
Employee Social Security number

_____
Employee and Domestic Partner Home Address

_____
Domestic Partner Signature Date

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If the employee and/or domestic partner is a resident of a State or City that provides for registration and/or dissolution of a domestic partnership, then State or City documentation for registration of domestic partnership must accompany this affidavit.

NOTARY ACKNOWLEDGEMENT

State of _____

County of_____

On this _____day of _____ in the year 20_____, before me, _____
(Notary's name)

a notary public for the State of _____ , personally appeared _____ and
(Employee's name)

_____, known to me to be the persons named in the foregoing instruments, and
(Domestic partner's name)

acknowledged to me that they executed the same as their free act and deed, for the uses and purposes therein mentioned.

_____ (Seal)
Signature of Notary Public

_____
Printed Name of Notary Public

Commission Expiration Date:_____

*Annual completion of this form will be required, during the open enrollment period, by both the employee and domestic partner to continue coverage on the domestic partner during the next plan year.

Please provide the original to the Idaho AGC Health Plan along with your enrollment forms, and any relevant State forms. Retain a copy for your records.