Print Form

PacificSource HEALTH PLANS

Affidavit of Domestic Partnership

This form should be used for dependent domestic partners only, in addition to a member enrollment form.

Policy No.:_____ Group Name (if applicable):_____

We, _____, and _____, certify that we
(Enrollee) (Domestic Partner)
meet the requirements set forth below in all respects.

1. We are each 18 years of age or older.
2. We are not related by blood closer than would bar legal marriage in Oregon where we have a permanent residence and are domiciled.
3. We have shared jointly the same permanent residence for at least six (6) months immediately preceding the date of an application to enroll and intend to continue to do so indefinitely.
4. We share an exclusive domestic partnership and have no other domestic partner.
5. Neither one of us has a legally binding marriage nor have we had another domestic partner within the previous six (6) months.
6. We were mentally competent to consent to contract when our domestic partnership began and remain mentally competent.
7. We agree that we are bound by and subject to all the provisions of the health plan.
8. We acknowledge and understand that willful falsification of information contained in this affidavit may result in the termination of our enrollment in the health plan and could result in a claim for damages or losses sustained by the health plan because of such willful falsification.
9. We understand that any coverage obtained by reason of this affidavit will terminate if we fail to meet any of the requirements of this affidavit as well as any applicable requirements of the underlying health plan.
10. We agree to notify the health plan policyholder in writing within 30 days of any change which would cause us to fail to meet any requirement of this affidavit, the underlying health plan.
11. We certify under penalty of perjury under the laws of the State of Oregon that the foregoing is true and accurate to the best of our knowledge.

Employee:_____ _____ _____
Signature Date Social Security No.

Domestic Partner:_____ _____ _____
Signature Date Social Security No.