



Domestic Partner Affidavit

To be completed by Employee and an Employer Representative

I and (name of domestic partner) _____ are domestic partners who meet the requirements set forth below in each and every respect.

1. We are not related by blood closer than first cousins.
2. Neither of us is married to anyone else nor have we had another domestic partnership within the most recent six months.
3. We share an exclusive and loving relationship that we intend to maintain for the rest of our lives.
4. We share a permanent residence with the intent to continue doing so indefinitely.
5. We maintain joint financial accounts and joint responsibility for basic living expenses including, but not limited to, food, shelter and living expenses.
6. We are each 18 years of age or older and were mentally competent to consent to contract when our domestic partnership began.

In addition, we understand that:

1. Enrollment is permitted only at times specified in the health plan.
2. We are obligated to notify my employer if there is any change that would cause us to fail to meet any requirement attested to above.
3. If we fail to meet any of the requirements attested to above, coverage for my domestic partner and my partner's children will terminate.
4. If our domestic partnership ends, my partner and any covered children of my partner are not eligible for federally mandated continuation of coverage. Portability coverage will be offered by the health plans to persons residing in the state of Oregon who meet the qualifications for Portability coverage.
5. If our domestic partnership terminates, I may not file a new Domestic Partner Affidavit earlier than six months after the domestic partner's coverage under my employer has been terminated.
6. Willful falsification of information contained in this affidavit may result in termination of our enrollment in the health plan and could result in a claim for damages, losses, including reasonable attorneys' fees and court costs incurred by the health plan because of such falsification.
7. There are terms and conditions set forth in the participation policies of AOI HealthChoice and in the health plan group contracts to which we agree to be bound. I further understand that AOI HealthChoice reserves the right to terminate group coverage on the date any fraudulent information is provided.

Printed names of Employee and Domestic partner: _____

Employee Signature: _____ Date: _____

Domestic Partner Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____