



MASSACHUSETTS

# AFFIDAVIT OF DOMESTIC PARTNERSHIP FOR BENEFITS ELIGIBILITY

When you add domestic partner coverage to your benefit program, the employee and their domestic partner must meet certain eligibility criteria. An affidavit is a means by which you may confirm that these eligibility requirements are met.

To help you ensure consistency with eligibility criteria and to help you obtain signed affidavits from domestic partners, we have included a sample affidavit. This affidavit includes the minimum information required to support the enrollment of a domestic partner. Please keep in mind that this sample affidavit contains suggested language. It can be adapted for your purposes so long as you obtain a signed statement from domestic partners attesting that they meet the eligibility criteria required in the rider. (See information following the affidavit for additional, optional language you may want to consider.)



# AFFIDAVIT OF DOMESTIC PARTNERSHIP

We, \_\_\_\_\_ and \_\_\_\_\_  
Employee (print) Domestic Partner (print)

represent, based on our own personal knowledge, that we meet all applicable eligibility requirements under the \_\_\_\_\_ benefit programs.  
Account Name

In addition, as domestic partners in an exclusive relationship, we acknowledge:

- We are at least eighteen (18) years of age or older and of legal age of consent;
- We are competent to enter into a legal contract;
- We share the same residence and intend to continue to do so;
- We are jointly responsible for basic living costs;
- We are in a relationship of mutual support, caring, and commitment in which we intend to remain;
- We are not married to anyone else; and
- We are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which we live.

**OR**

We do not meet the all of the above bulleted criteria but are registered as domestic partners with the state or municipality in which we live.

We affirm, under penalty of perjury, that the assertions in this affidavit are true and accurate to the best of our knowledge. If we misrepresent or provide false information, we agree that our membership may be terminated (including retroactively) at the discretion of Blue Cross and Blue Shield of Massachusetts and/or the Account.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Domestic Partner Signature

\_\_\_\_\_  
Date



## OPTIONAL ADDITIONS

Here are some optional, additional statements and documentation that you may wish to include in your affidavits, including a Statement of Termination of Domestic Partnership that you may require an employee or their domestic partner to sign in order to terminate coverage for a domestic partner. However, we urge you to discuss these optional requirements with your own legal counsel before adopting policies and including such language in your affidavits.

### Documentation Proving Eligibility Criteria

You may wish to require that your employee and their domestic partner provide you with documentation that indicates that they generally meet the criteria in the affidavit or that they meet specific requirements, such as joint residency or joint responsibility for living expenses. Here is an example of language that you might consider for your affidavit:

"We acknowledge that the Account may reasonably request, as it deems necessary, other documentation, which reflects our joint financial responsibilities."

### Notice Requirements

You may wish to include a statement in the affidavit in which the domestic partners agree to notify you of any changes in their domestic partner status that affects their eligibility. Here is some sample language:

"We agree to notify the Account if there is any change in our status as domestic partners which would make us no longer eligible for the Account's benefits (for example, a change in joint residence or if we are no longer each other's sole domestic partner). We will notify the Account within \_\_\_\_\_ days of such change by filing a Statement of Termination of Domestic Partnership ("Statement of Termination"). The Statement of Termination shall affirm that the domestic partnership status is terminated as of its date of execution and that a copy of the Statement of Termination has been mailed to the other party by the party authorizing such action."

"After such termination, I, \_\_\_\_\_, understand that a subsequent Affidavit of Domestic Partnership  
Employee Name  
cannot be filed until 12 months after a Statement of Termination has been filed with the Account. The 12-month waiting period will be waived only if another affidavit is filed for the same domestic partner within 31 days following the filing date of the Statement of Termination."

"We understand that as domestic partners we are subject to the same 30-day notice requirement as set forth in the Account's benefit programs, as are all other employees of the Account who are covered by applying for the Account's benefits."

### Statement Regarding Use and Confidentiality of Affidavit

You may wish to include language in the affidavit that advises the domestic partners how you will use the information and keep information confidential to minimize subsequent complaints. Here is sample language:

"We have provided the information in this affidavit for use by the Account's Human Resources Department for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that the Account shall make a good faith effort to keep information obtained in the Affidavit of Domestic Partnership in confidence and to restrict access to such information on a "need-to-know" basis. We also understand that such information will not be disclosed without the written consent of both parties except that the Account may provide a copy of this Affidavit to Blue Cross and Blue Shield as evidence of eligibility."



## Employer Rights

You may wish to include a statement that confirms your rights regarding termination of coverage. Here is an example of language:

“The Account, in accordance with the eligibility requirements of its benefits programs, reserves the right to terminate, modify, or adjust its benefits programs at any time in its sole discretion.”

## Other Acknowledgments

Here are samples of other acknowledgements that you may require of employees and their domestic partners:

“We understand that should the Account or any other person or entity suffer any loss due to any false statement contained in this affidavit they may bring a civil action against either or both of us to recover their losses, including reasonable attorney’s fees. Furthermore, we understand that if it is determined that any false statements are contained in this affidavit or we fail to provide updated information as required herein, our health coverage may be terminated upon 60 days notice retroactive to the date this affidavit was signed.”

“We understand that domestic partners and their eligible dependents are eligible for continuation of coverage rights for health insurance to the extent that legal spouses and their dependents are entitled to such similar rights under federal or state law.”

“We understand that premiums or parts of premiums for individual coverage may be included in the employee’s reported gross income for tax purposes.”

## Internal Use Only Section

You may wish to include a section at the end of the affidavit for internal use only in which you acknowledge receipt of the affidavit or Statement of Termination with signature lines and dates.

# STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

1. I, \_\_\_\_\_, state the following based upon my own personal knowledge:

Employee or Domestic Partner (print)

\_\_\_\_\_ and I are no longer domestic partners.

Name of Employee or Domestic Partner

2. I make and file this Statement of Termination in order to cancel the Affidavit of Domestic Partnership,

dated \_\_\_\_\_.

Effective Date of Termination

The above date is within 30 days of the termination of our domestic partnership.

3. I mailed my former domestic partner a copy of this notice at:

\_\_\_\_\_ on \_\_\_\_\_.

Former Domestic Partner's Address

Date Mailed

4. I affirm, under penalty of perjury, that the assertions in this statement are true to the best of my knowledge.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_



Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).