

Anthem Blue Cross and Blue Shield Statement of Domestic Partnership

Note: Keep a copy of this document for your records and send the original attached with your Enrollment/Change Application.

Policy Holder/Subscriber

Policy # _____
(for existing members only)

Name _____

Home Address _____

Social Security # _____

Birth Date: _____

Domestic Partner

Name _____

Social Security # _____

Home Address _____

Birth Date: _____

We the undersigned attest to the following:

- 1) Each party is the sole Domestic Partner of the other.
- 2) Each party is at least eighteen (18) years of age.
- 3) Both parties currently share a common legal residence and have shared said residence for at least 12 months prior to application for Domestic Partner coverage.
- 4) Neither party is married to another person.
- 5) Both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future.
- 6) Neither party is related to the other by adoption or blood to a degree of closeness that would bar marriage in the state in which they reside, except for those states that legally recognize Domestic Partners as a legal valid marriage.
- 7) Domestic Partners are responsible for basic living expenses.
- 8) Domestic Partners must have in effect and provide proof of any one of the following:
 - a) Designation of the Partner as beneficiary for life insurance and retirement contract; or
 - b) Designation of the Partner as primary beneficiary in the Policy Holder/Subscriber's will; or
 - c) Documentation by one Partner designating the other Partner as his/her agent for:
 - Personal relationship issues, or
 - Health Care decisions, or
 - Health Care agent
- 9) Neither party has filed a Termination of Domestic Partnership within the preceding 12 months.

Signatures and Notary Public Seal required on next page. Please submit both pages with your application.

SWORN STATEMENT

We declare that all the foregoing information provided by us is true and correct and that all provisions of this Statement have been met.

We understand that:

- Any entities or persons, including, but not limited to, Anthem Blue Cross and Blue Shield (Anthem BCBS) who suffer any loss because of any false statements contained in this Statement may bring a civil action suit against us to recover their respective losses, including reasonable attorney’s fees; and
- If there is any change in the information certified in the Statement of Domestic Partnership that would make the Domestic Partner ineligible, the employee must complete and file a Termination of Domestic Partnership form within 30 days of the change, and
- *Coverage for the Domestic Partner and eligible dependents of the Domestic Partners will be as follows:*

- 1) Upon initial enrollment, provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS.
- 2) Policy Holder/Subscriber may enroll a Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS. The Effective Date of coverage will be in accordance with any applicable waiting period in place by the (*Policy Holder*) Anthem BCBS.

We agree to notify Anthem Blue Cross and Blue Shield if our domestic partnership no longer meets the criteria established herein.

Subscriber’s Signature

Domestic Partner Signature

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 200 __, before me personally appeared _____ and _____, to me known to be the persons described herein, and who executed the foregoing, and swore to its truth.

Before me, _____
Notary Public Signature and Commission Exp. Date