



# Domestic Partner Registration and Affidavit

Quartz

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<b>SUBSCRIBER INFORMATION</b>
Name (first, middle, last):
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Employer Group Name:
<b>DOMESTIC PARTNER INFORMATION</b>
Name (first, middle, last):
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>ADDRESS INFORMATION OF RESIDENCE SHARED BY BOTH DOMESTIC PARTNERS</b>
Street Address:
City:
State: ZIP Code:
<b>In addition, the following child(ren) of such Partner full qualify as my dependent under Internal Revenue Code (IRC) Section 152(a)(9)</b>
Child 1 Name:
Child 2 Name:
Child 3 Name:
Child 4 Name:

To show your status as Domestic Partners please provide copies of two of the following documents. Please check the ones you are submitting. **NOTE: at least one of your submitted documents must show proof that it has been in effect for at least six months.**

<input type="checkbox"/> Joint purchase and ownership of a home	<input type="checkbox"/> Notarized copy of lease naming both Domestic Partners
<input type="checkbox"/> Evidence of joint checking or savings account	<input type="checkbox"/> Evidence of joint use and liability for credit cards
<input type="checkbox"/> Title and registration of joint ownership of automobile	<input type="checkbox"/> Evidence that domestic partner is a beneficiary under Subscriber's deferred compensation retirement plan
<input type="checkbox"/> Certified copy of life insurance policy evidencing Domestic Partner as beneficiary	<input type="checkbox"/> Subscriber's Last Will and Testament evidencing that Domestic Partner is a major recipient of estate proceeds
<input type="checkbox"/> Evidence of Durable Powers of Attorney (per ss. 243.07, 243.10, 155.05 and/or 155.10 Wis. Stats.)	

Other: Documentary evidence which depicts significant joint financial interdependency between the Subscriber and Domestic Partner – please describe:

## AFFIDAVIT OF DOMESTIC PARTNERSHIP DECLARATION

We, \_\_\_\_\_(Subscriber) and \_\_\_\_\_(Domestic Partner) certify that we are domestic partners in accordance with the following criteria and affirm that all of the below partnership requirements were met on (insert date the relationship began):\_\_\_\_\_.

1. We are at least 18 years of age and mentally competent to consent to a contract.
2. We have lived together for at least six months prior to enrollment in the plan.
3. We are not legally married to anyone else nor have another domestic partner.
4. We are not related by marriage.
5. We are not related by blood closer than permitted under the marriage laws of the State of Wisconsin.
6. We have entered in the domestic partnership relationship voluntarily, willingly, and without reservation.
7. We have entered into a relationship which is the functional equivalent of a marriage and which includes all of the following:
  - A. Living together as a couple;
  - B. Mutual support of each other;
  - C. Mutual caring and commitment to one another;
  - D. Mutual fidelity.
  - E. Mutual responsibility for each other's welfare; and
  - F. Joint responsibility for the necessities of life.
8. We intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at the will of either partner.
9. We can provide all or some types of documentation indicated below if requested -
  - Domestic Partner Affidavit
  - 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.
  - Joint mortgage or lease.

## CHANGE IN DOMESTIC PARTNERSHIP

We agree to notify Unity Health Insurance within 30 days of any change in Domestic Partnership status which would make the Domestic Partner no longer eligible for benefits (e.g. a change in join residency) by filing a Statement of Termination of Domestic Partnership. The Statement of Termination shall affirm that the Domestic Partnership status is terminated as of the date of execution specified therein and that a copy has been mailed to the other party by the party authorization of the action.

Upon termination of this Affidavit of Domestic Partnership (evidenced by a Statement of Termination of the Partnership signed by the insured), I \_\_\_\_\_(Subscriber) agree that another Affidavit of Domestic Partnership cannot be filed for a minimum of six months.

We have read and understand the provisions of the Domestic Partner Rider. We agree that the giving of false, inaccurate or misleading information may result in the payment of unauthorized benefits and may result in legal, financial and other penalties as provided by law. We further understand that both the Employer and Unity Health Insurance retain the right to verify, at any time, any and / or all of the information set forth herein. We have reviewed the information we have provided herein and the attached documentation and we both, and each of us

singly, do hereby certify that the foregoing is true and correct to the best of our knowledge.

\_\_\_\_\_  
Subscriber Signature

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

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

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

Your health plan is {UTY Underwritten By:30421}

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