



# Regence

Regence BlueShield  
1800 Ninth Avenue  
Seattle, WA 98101

Regence BlueShield is an Independent Licensee  
of the Blue Cross and Blue Shield Association

Please return the completed form.

By Mail: PO Box 1200  
Portland, OR 97207-1200

By Fax: 1 (866) 303-5117

## AFFIDAVIT OF QUALIFYING DOMESTIC PARTNERSHIP

### SECTION I - Statement of Domestic Partnership

Name of Employee _____																																									
ID Number <table border="1" style="display: inline-table; width: 150px; height: 20px; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																					Group Number <table border="1" style="display: inline-table; width: 150px; height: 20px; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																				
Domestic Partner's Name _____	Date Domestic Partnership Began _____																																								

I certify that \_\_\_\_\_ and I are domestic partners and that we meet the following criteria:  
Name of Domestic Partner (please print)

- ◆ We are 18 years of age or older;
- ◆ We share a close personal relationship and are each other's sole domestic partner;
- ◆ We are responsible for each other's common welfare;
- ◆ We are not legally married to anyone else nor has either of us had another domestic partner within 30 days immediately prior to this application to enroll on coverage;
- ◆ We are not related by blood closer than would bar marriage in our state of residence;
- ◆ We currently share the same regular and permanent residence and intend to continue to do so indefinitely; and
- ◆ We jointly share financial responsibility for "basic living expenses," including the cost of food, shelter, and other costs such as medical expenses.

### SECTION II - Change in Domestic Partnership

I, the employee [or "We"] agree to notify the Group within 30 days of any change in our domestic partnership status that would make the domestic partner no longer eligible under the above criteria, and such notice will be treated as a request for termination of the domestic partner. I, the employee, understand that another Affidavit of Qualifying Domestic Partnership cannot be filed within 90 days after a request for termination of a domestic partner has been filed with the Group. This termination provision shall not apply to any termination of domestic partnership that occurs as a matter of law because the parties to the domestic partnership enter into a marriage to each other (including any entry into marriage by virtue of an automatic conversion of the domestic partnership into a marriage).

### SECTION III - Acknowledgment

We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization, in any action involving the enrollment or eligibility of the domestic partner, or if otherwise required by law. We understand that this declaration of responsibility for our common welfare may have legal implications under our State law. We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, arising from a false statement contained in the Affidavit of Qualifying Domestic Partnership. We also certify under penalty of perjury, under our State laws, that the foregoing is true and correct. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

▶	▶	▶	▶
Signature of Employee	Date	Signature of Domestic Partner	Date

Address \_\_\_\_\_

City, State and ZIP Code \_\_\_\_\_

