AFFIDAVIT OF DOMESTIC PARTNERSHIP FOR STATE OF MAINE GROUP PLANS

Definition of Domestic Partnership as defined for coverage under the State of Maine group plans: A person of the same or opposite sex as the subscriber, neither of whom is married to another person, who can demonstrate shared financial obligations, shared primary residence, and shared responsibility for the welfare of the subscriber.

We,_____and_____(domestic partners), after being first duly sworn depose and attest to the following:

- We are at least 18 years of age and we are mentally competent to contract.
- Neither of us is legally married to or separated from another person.
- We share financial obligations and primary residence (same address).
- We are sole domestic partners, we have been sole domestic partners since_____(month/day/year), and we intend to remain sole partners. (Domestic partnership and any supporting documentation must be in effect for 6 months in order to be considered a "domestic partnership" for insurance coverage under the State of Maine group.)
- We are not related by blood to a degree of closeness that would prohibit marriage in the State of Maine.
- Neither of us has covered another individual or has been covered by another individual as a domestic partner or a legal spouse in a health insurance policy in the preceding 6 months. We understand that domestic partners cannot enroll together for 6 months following the termination of coverage of a prior domestic partner or legal spouse.
- We are jointly responsible for each other's common welfare as evidenced through a joint deed, joint mortgage, joint lease, joint credit card or joint bank account, listed as a beneficiary on the employee's retirement/pension plan and/or powers of attorney authorizing each of us to act on behalf of the other. **(At least one of these items must be provided along with this affidavit and must have been in effect for at least 6 months).**
- We understand that a domestic partner enrolled as a dependent ceases to be an eligible member on the first of the month following the termination of a domestic partnership and that we are required to submit an Application for Change within 30 days of the termination of a domestic partnership.

We certify under penalty of perjury, that the foregoing is true and correct. We, the undersigned employee and the Domestic Partner, understand that the falsification of information contained in the Affidavit may lead to disciplinary action up to and including immediate termination of the employee's employment, and may subject us to civil action to recover any losses, including reasonable attorney's fees incurred by the State of Maine or by its Plan Administrator for the benefits provided under the State of Maine Group Health Plan.

Employee Signature:_____Date:_____Social Security #:_____

Department Name:_____

Address:_____City:_____Zip: _____

Domestic Partner Signature:_____Date:_____Social Security#:_____

Please return form to:

Employee Health,
Wellness, & Workers'
Compensation
61 State House Station
Augusta, ME 04333-0061

(207) 624-7380 or 1-800-422-4503
TTY dial Maine Relay 711
www.maine.gov/bhr/oeh

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