Blue Cross and Blue Shield of Montana
Affidavit of Domestic Partnership

I, ________________________________ (print name of Employee) certify that I and ________________________________(print name of Domestic Partner/Cohabiter) reside together at:____(address) as a non-married cohabiting couple and we intend to cohabit indefinitely and share the common necessities of life.

We affirm that:

1. Neither is, or has been for the past 6 months, married, legally separated, a cohabiter or a domestic partner to another;
2. We have cohabitated for at least 6 months, continue to cohabitate, and the effective date of the Domestic Partnership was _______________;
3. We are at least 18 years of age and mentally competent to consent to contract and mentally competent to execute this Affidavit;
4. We are not related by blood to a degree that would bar marriage in the State of Montana;
5. We are each other's sole Domestic Partner and intend to remain so indefinitely;
6. We are responsible for each other's common welfare and have a financial interdependent relationship evidenced by any of the following:

   a. Mutually granted financial or health care powers of attorney;
   b. Designation of each other as primary beneficiary in wills, life insurance policies or retirement plans;
   c. Executed a joint lease, mortgage or deed; or
   d. Have joint ownership of a banking account;

Change in Status:

We agree to notify the Employer if there is any change of circumstances, including, for example, a change in address or in tax dependent status, attested to in this Affidavit within thirty (30) days of said change. Failure to notify the Employer within 30 days shall result in the Employee being responsible for any benefits provided or monies paid by the Employer, Plan or Insurer on behalf of the Domestic Partner/Cohabiter after the date of termination

Acknowledgement:

We understand that any persons/employer/company who suffer any loss because of a false statement contained in any Affidavit of Domestic Partnership/Cohabiter Affidavit may bring a civil action against us to recover their losses including reasonable attorneys' fees, unless another right of recovery is provided by the Employer's Human Resource policies.

We provide the information in this Affidavit to be used by the Employer for the sole purpose of determining our eligibility for Domestic Partnership/Cohabiter benefits. We understand that this information will remain confidential and will be subject to disclosure only upon our express written authorization or as legally required.

We are aware that a Domestic Partner/Cohabiter and the Dependent children of a Domestic Partner/Cohabiter may not qualify as dependents of the Employee under Section 152 of the Internal Revenue Code.

We understand that under the Federal Family and Medical Leave Act, the Employer is not required to grant family leave to an Employee in order to care for his or her Domestic Partner. Also, Domestic Partners are not entitled to coverage under Medicare Secondary Payer provisions.

We affirm, under penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge. We understand that this form is not an application for insurance coverage and the purpose of this form is to establish the eligibility of the persons named herein for the coverage provided under the Employer's employee benefits program.

______________________________ ____
Date Signature of Employee

____
Date of Birth

______________________________ ____
Date Signature of Domestic Partner

____
Date of Birth

Subscribed and sworn to before me this __________ day of _________, 20___.

____
Notary Public for the State of Montana

(NOTARY SEAL)

____
Printed Name of Notary
Residing at ___________________________
Date My Commission expires: _____________