Blue Cross and Blue Shield of New Mexico

Affidavit of Domestic Partnership

DECLARATION

We certify that _____ is a Domestic Partner of _____
Domestic Partner's name (please print) Employee's name (please print)
in accordance with the following eligibility criteria. We certify we met the following eligibility criteria for establishing Domestic Partnership as of _____.
Date

1. We have lived together for at least six months.
2. We are not married to anyone else nor have another Domestic Partner.
3. We are at least 18 years of age and mentally competent to consent to contract.
4. We reside together in the same residence and intend to do so indefinitely.
5. We have an exclusive mutual commitment similar to that of marriage.
6. We are jointly responsible for each other's common welfare and share financial obligations. We can provide two (2) or more types of documentation indicated below:
    - Joint mortgage or lease
    - Designation of Domestic Partner as beneficiary for life insurance or 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

    (BCBSNM reserves the right to request this supporting documentation at any time.)

CHANGE IN DOMESTIC PARTNERSHIP

We agree to notify the Group within thirty (30) days of any change in Domestic Partnership status that would make the Domestic Partner no longer eligible for benefits (e.g., a change in joint residency) by filing a *Statement of Termination of Domestic Partnership*. The *Statement of Termination of Domestic Partnership* 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 authorizing the action. Upon termination of this *Affidavit of Domestic Partnership* (evidenced by a *Statement of Termination of Domestic Partnership* signed by the Insured), I _____ agree that another *Affidavit of Domestic Partnership* cannot be filed for a minimum of six months.

ACKNOWLEDGEMENTS

We have provided this information in this Affidavit for the sole purpose of determining our eligibility for Domestic Partnership benefits.

_____
Employee Signature Date

_____
Employee Social Security number

_____
Employee and Domestic Partner Home Address

_____
Domestic Partner Signature Date

On this _____, day of _____, 20_____, before me personally came_____, to me known to be the individual described as "Employee/Insured" and the individual described as "Domestic Partner" in the above document entitled "AFFIDAVIT OF DOMESTIC PARTNERSHIP" and who executed same as a free and voluntary act for the uses and purposes stated herein.

_____
Notary Public My Commission Expires

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Please provide the original to your employer along with your application. Retain a copy for your records.