Regence

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

Regence BlueCros BlueShield of Oregon
100 SW Market Street
PO Box 1271
Portland, Oregon 97207-1271

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 | | | | | | | | | | Group Number | | | | | | | | |

Domestic Partner's Name _____ Date Domestic Partnership Began (mm/dd/yyyy) _____

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.

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.

▶ _____ (mm/dd/yyyy) _____
Signature of Employee — Date

▶ _____ (mm/dd/yyyy) _____
Signature of Domestic Partner — Date

_____
Address

_____
City, State and ZIP Code

F5202.XOR0EN12100101