Domestic Partner Declaration Application

Aspirus Health Plan, Inc. (“Aspirus Health Plan” or “Insurer”) or Third-Party Administrator (TPA) does not guarantee approval of this application for any person, or issuance of a policy.

Return a copy of completed form to: Aspirus Health Plan, ATTN: Enrollment, PO Box 1062, Minneapolis, MN 55440
or email to: Enrollment@aspirusheathplan.com. If you have questions, please call Customer Service at: 866.631.5404.

SECTION 1

We, the undersigned, attest and certify that we are each other’s sole domestic partner.

Employee Name	Domestic Partner Name

DOMESTIC PARTNERS ARE DEFINED AS TWO INDIVIDUALS:

1. Who are in a committed relationship of mutual support, caring, and commitment with the intention to remain in such a relationship in the immediate future;
2. Who are financially responsible for each other’s well-being and debts to third parties;
3. Who are not married or legally separated in marriage, and who have not been a party to an action or proceeding for divorce or annulment within six months of registration, or if one has been married, at least six months have elapsed since the date of the judgment terminating the marriage;
4. Who are not currently registered in another designated partnership, and if one party has been in such a registered relationship, at least six months have lapsed since the effective date of termination of that registered relationship before the registration of the current domestic partnership;
5. Who are each 18 years of age or older and competent to contract;
6. Who are not related by blood closer than would bar marriage in the state of their residence;
7. Who live together in the same dwelling unit as a single non-profit housekeeping unit and have a relationship that is of a permanent and domestic character;
8. Whose relationship is not temporary, social, political, commercial, or economic in nature;
9. Whose relationship has existed for at least six months;
10. Who are not registered with any other domestic partnership;
11. Who, for at least the six-month period immediately preceding the date of this Declaration, have either:
    a. Obtained a domestic partnership certificate from the city, county, or state of residence or from any other city, county, or state offering the ability to register a domestic partnership; or
    b. Any three of the following with respect to the domestic partner (check those which apply):
       - ☐ joint lease, mortgage, or deed;
       - ☐ joint ownership of a vehicle;
       - ☐ joint ownership of a checking account or credit account;
       - ☐ designation of the domestic partner as a beneficiary of the covered employee’s will;
       - ☐ designation of the domestic partner as a beneficiary of the covered employee’s life insurance or retirement benefits;
       - ☐ designation of the domestic partner as holding power of attorney for health care; or
       - ☐ shared household expenses.

SECTION 2

1. I understand that coverage for my domestic partner and his/her dependents shall terminate upon the death of my domestic partner or upon a change of circumstances attested to in Section 1 above.
2. I understand that I am obligated to file a Declaration of Termination of Domestic Partnership with Aspirus Health Plan within 30 days of the death of my domestic partner, or the date on which my domestic partner and I no longer meet the criteria for domestic partners outlined in this document, whichever is earlier.
3. I understand that falsely certifying eligibility for domestic partner benefits or failing to inform Aspirus Health Plan if the domestic partnership ceases to meet the eligibility requirements in any respect may lead to disciplinary action, including discharge from employment.
4. I understand that upon submission of this Declaration, I am required to provide evidence of my domestic partnership as indicated on the reverse side of this document.

SECTION 3

1. The covered employee and the domestic partner (hereinafter referred to as "We") hereby certify that we are each other's sole domestic partners as defined above.
2. We have provided the information in this Declaration for use by Aspirus Health Plan and its employees for the sole purpose of determining eligibility of the domestic partner and dependent children of the domestic partner under those policies, guidelines, practices, and benefit plans that provide coverage for domestic partners as from time to time established by Aspirus Health Plan. We understand that Aspirus Health Plan and its employees are permitted to use the information provided on this Declaration to administer the benefits outlined above.
3. We understand and agree that the employer is not legally required to extend such benefits to domestic partners and that the employer, in its sole discretion, may change or terminate these benefits, policies, guidelines, and practices at any time without consent of any employee or group of employees.
4. We understand that under federal and state law, benefit coverage of the non-employee domestic partner and his/her children may result in imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes).
5. We understand that, in addition to this Declaration, certain benefit plans require the completion of forms to enroll or disenroll a domestic partner and any eligible dependents.
6. We understand that a civil action may be brought against one or both of us for any losses, including attorney's fees and court costs, because of any false statement(s) contained in this Declaration or for failure to notify Aspirus Health Plan of a change in circumstances required in Section 2. We agree that each of us is, and agrees to be, jointly and severally liable for such losses.
7. We understand that this Declaration may have legal implication relating, for example, to our ownership of property or to taxability of benefits provided. We understand that before signing this Declaration we should seek competent legal and tax advice concerning such matters. We acknowledge that the employer or Aspirus Health Plan has provided us with no advice in this regard.
8. We understand that failure to provide complete, true, timely, and correct information may result in loss of benefit plan coverage.

We have read and understand the terms and conditions contained in the Declaration of Domestic Partnership. We affirm, under penalty of perjury, that the statements in this Declaration are true, complete, and correct.

Employee's Signature	Employee's Name *(Please print)*	Date
Domestic Partner's Signature	Domestic Partner's Name *(Please print)*	Date

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