HEALTH REPUBLIC
INSURANCE

DECLARATION OF DOMESTIC PARTNERSHIP

We, _____ and _____, each certify and declare that
(employee-print name) (domestic partner-print name)
we are domestic partners in accordance with the following criteria:

1. We affirm that this domestic partnership began on or about __/__/__.

2. We are each other's sole domestic partner, and we intend to remain so indefinitely.

3. Neither of us is married to or legally separated from anyone else nor have had another domestic partner within the prior six months.

4. We are both at least eighteen (18) years of age and mentally competent to consent to contract.

5. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.

6. We cohabit and reside together in the same residence and intend to do so indefinitely. We have resided in the same household for at least six months.

7. We are not in this relationship solely for the purpose of obtaining benefits coverage.

DEPENDENT CHILDREN OF DOMESTIC PARTNER

We understand that dependent children of _____ are eligible for coverage when they are:
(domestic partner-print name)

- unmarried,
- primarily dependent on the employee for support, and
- meet the age/school and all eligibility requirements of the plan of benefits.

ACKNOWLEDGMENTS

We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in this Declaration or for failure to notify the employer of changed circumstances. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify changed circumstances, may lead to disciplinary action against me, including discharge from employment.

We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

_____	__/__/__	__/__/__
Employee Signature	DOB	Date
_____	__/__/__	__/__/__
Domestic Partner Signature	DOB	Date