Affidavit of domestic partnership

ConnectiCare

1. Declarations: (please print)

We, _____ and _____ certify that we are domestic
(Print name of applicant) (Print name of partner)
partners in accordance with the following criteria and eligible for benefits coverage as Domestic Partners under ConnectiCare's Individual HMO/POS (called the "Plan") benefits program.

2. Status:

1. We are at least 18 years of age and mentally competent to consent to contract;
2. We are not legally married to each other and neither of us is legally married to any other person;
3. We are not related by blood to any degree that would bar marriage in our state of residence;
4. We have been committed to this relationship for at least 12 months.
5. We reside together in the same residence and have so resided for the last 12 months;
6. We intend to reside together in the same residence indefinitely;
7. We are each other's sole domestic partner and intend to remain so indefinitely;
8. We are jointly responsible for each other's common welfare and financial obligations.

3. Proof:

We understand that ConnectiCare may require proof of our status as Domestic Partners, including up to three of the following types of documentation, and we are able to provide such documentation:

- ☐ Joint ownership or lease of a residence (e.g. home, condominium, etc.) identifying us both either on the deed as co-owners, or on the lease as co-renters;
- ☐ Joint ownership of a checking, savings or investment account;
- ☐ Joint residence (e.g. copy of driver's license);
- ☐ Each other named as the primary beneficiary on any life insurance policy, pension, etc.;
- ☐ Each other named as power of attorney for health care decisions;
- ☐ Entered into a legally executed contractual agreement accepting responsibility for each other's third party debts.

4. Change in domestic partnership:

We agree to notify the Plan if there is any change in our status as domestic partners as attested to in this Affidavit which would make us no longer eligible for benefits. We will notify the Plan within thirty (30) days of such change by filing a Statement of Termination of Domestic Partnership with the Plan. The Statement of Termination of Domestic Partnership shall affirm that the domestic partnership status is terminated as of the date of its execution and that a copy of the Statement has been mailed, postage prepaid, or hand-delivered to the other partner by the party authorizing such action.

5. Acknowledgements:

1. We acknowledge that any person/company who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us to recover their losses, including attorneys' fees;
2. We have provided the information in this Affidavit for use by the Plan and for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that the information contained in this Affidavit is confidential and will not be released by the Plan unless expressly authorized by either or both of us, or except otherwise required by law, or except as required to providers and insurers of domestic partnership benefits;
3. We acknowledge that our domestic partnership has been entered into voluntarily and willingly;
4. We understand that this Affidavit may create between us certain contractual rights and legal obligations and, that the Plan has encouraged us to seek independent legal advice about those rights and obligations;
5. We affirm, under the penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge.

Applicant's signature	Date	Partner's signature	Date
	/ /		/ /
Address		Address	

ConnectiCare

Language & Non-Discrimination Notice

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, Phone: 1-800-251-7722, and TTY: 711. You can file a grievance in person or by mail. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-251-7722 (TTY: 711）。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 (TTY: 711)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-251-7722 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-251-7722 (TTY: 711) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-251-7722 (TTY: 711)។

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-251-7722 (TTY: 711).