BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

# STATEMENT OF DOMESTIC PARTNERSHIP

Note to Group: Keep a copy of this document for your records and, if applicable, submit the original Statement with the appropriate Group Enrollment and Change Form.

## Group

Number _____

Name _____

## Employee

Name _____ Member ID # _____

Home Address _____ Social Security # _____

Birth Date _____

## Domestic Partner

Name _____ Member ID # _____

Home Address _____ Social Security # _____

Birth Date _____

### We the undersigned attest to the following:

- each party is the sole domestic partner of the other;
- each party is at least eighteen (18) years of age or older and competent to enter into a contract in the state in which he or she resides;
- parties currently share a common legal residence and have done so for at least six (6) months
- neither party is married, a party to a Civil Union, or related to the other by adoption or blood to a degree of closeness that would bar marriage/Civil Union in the state in which they legally reside;
- both parties are in a relationship of mutual support,caring, and commitment and intend to remain in such a relationship in the indefinite future;
- the parties are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household; the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

## SWORN STATEMENT

We declare that all the foregoing information provided by us is true and correct and that all provisions of this Statement have been met.

### We understand that:

- any entities or persons (including, but not limited to, Blue Cross and Blue Shield of Vermont) who suffer any loss because of any false statements contained in this Statement may bring a civil action suit against us to recover their respective losses, including reasonable attorney's fees;
- if there is any change in the information certified in the Statement of Domestic Partnership that would make the domestic partner ineligible, the employee must complete and file a Termination of Domestic Partnership form within 30 days of the changes; and
- the effective date of coverage for the domestic partner and any initially eligible dependents of the domestic partner is:
  - on the open enrollment date if Blue Cross and Blue Shield of Vermont receives the Statement of Domestic Partnership and application form before your group open enrollment date; or
  - the first of the month following the group open enrollment date if Blue Cross and Blue Shield of Vermont receives the Statement of Domestic Partnership and application form during the month in which the group's open enrollment date occurs.

**We agree to notify the employer if our domestic partnership no longer meets the criteria established herein.**

_____ _____

Employee Signature Domestic Partner Signature

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 20____ before me personally appeared _____ and _____, to me known to be the persons described herein, and who executed the foregoing, and swore to its truth.

Before me, _____

Notary Public Signature and Commisson Exp. Date

## ATTACHMENTS

If required, attached to this document is the following documentation in support of this Statement of Domestic Partnership:

- proof of common residence—e.g.,driver's licenses showing same address, passports or designations for receipt of mail; and
- proof of financial interdependence—e.g., joint checking, savings or credit card statements, executed powers of attorney, insurance policies, and/or copies of designated signatures on safety deposit boxes.

# Disclaimers

## General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit **bluecrossvt.org/contracts**, click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

## How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

### NOTICE: Discrimination is Against the Law

BlueCross and BlueShield of Vermont (Blue Cross) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, **contact civilrightscoordinator@bcbsvt.com**

If you believe that Blue Cross has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Kienan D. Christianson, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583, fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Kienan D. Christianson, Civil Rights Coordinator 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 or 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

**For free language-assistance services, call (800) 247-2583.**

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| ARABIC | للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583. lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583. |
| CHINESE | 如需免费语言协助服务，请致电, (800) 247-2583. Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583. |
| CUSHITE (OROMO) | Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 bilbili. |
| FRENCH | Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583. |
| GERMAN | Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 an. |
| ITALIAN | Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583. |
| JAPANESE | 無料の言語支援サービスについては, (800) 247-2583. Muryō no gengo shien sābisu ni tsuite wa ,(800) 247-2583 made o denwa kudasai. |
| NEPALI | निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583. Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583. |
| PORTUGUESE | Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583. |
| RUSSIAN | Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583. |
| SERBO-CROATIAN (SERBIAN) | За бесплатне услуге језичке помоћи позовите (800) 247-2583. Za besplatne usluge jezičke pomoći pozovite (800) 247-2583. |
| SPANISH | Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583. |
| TAGALOG | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583. |
| THAI | สำหรับบริการช่วยเหลือด้านภาษา ฟรี โทร,(800) 247-2583. S̄āh̄rạb brikār chwyh̄elūx d̄ān phās̄'ā frī thor (800) 247-2583. |
| UKRAINIAN | Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583. Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 |
| VIETNAMESE | Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583. |