AFFIDAVIT OF DOMESTIC PARTNERSHIP
North Dakota University System

Declaration of Domestic Partnership Status.

We,_____, Member, and _____ Domestic Partner, each certify and declare that we are each other's sole domestic partner as set forth in this Declaration.

We are both at least eighteen (18) years old and mentally competent to consent to a civil contract; and

We are not acting under force or duress; and

Neither of us is currently married to or legally separated from any other person and neither of us is engaged in another Domestic Partner relationship; and

We are not related by blood or marriage to a degree of closeness that would prohibit legal marriage in the state in which we reside; and

We are engaged in a committed relationship of mutual caring and support and are jointly responsible for our common welfare including financial interdependence; and

We have been in this committed relationship for a period of at least twelve (12) consecutive months and intend to reside with each other permanently.

Establishment of this Domestic Partner relationship and financial interdependence must be established by providing documentation for at least two (2) of the following: Joint lease, mortgage or deed; joint ownership of a motor vehicle; joint ownership of a checking, savings or credit card account; joint responsibility on household utility expenses; or designation of the Domestic Partner as a beneficiary for the student's life insurance.

The Domestic Partner is not now covered nor has the ability to obtain coverage from their respective employer or under any other group health plan.

Termination of Domestic Partnership.

Member and Domestic Partner acknowledge an obligation to ensure that Blue Cross Blue Shield of North Dakota (BCBSND) receives written notice of a Declaration of Termination of Domestic Partnership if there is any change in the Domestic Partner status rendering this Affidavit invalid or erroneous. Notice shall be provided to BCBSND within thirty-one (31) days of such change.

Member and Domestic Partner acknowledge that termination of benefit coverage obtained as a result of this Affidavit will be effective on the last day of the month during which the Domestic Partnership ends or at such time as coverage terminates in accordance with the terms and conditions of the North Dakota University System (NDUS) health benefit plan. Receipt of a Declaration of Termination of Domestic Partnership by BCBSND shall be deemed conclusive evidence of the termination of the Domestic Partnership status for the purpose of receiving benefits under the NDUS health benefit plan.

Statement of Eligibility.

Is the Domestic Partner eligible for health benefits from their employer? ☐ Yes ☐ No

- If the answer is "Yes" to the above question, the Domestic Partner is NOT eligible for benefits under the NDUS health benefit plan.
- If the answer is "No" to the above question, the Domestic Partner is eligible for benefits under the NDUS health benefit plan.

Name of Domestic Partner's employer: _____

Acknowledgement.

We have provided information in this Affidavit for use by BCBSND for the sole purpose of determining our eligibility for benefits under the NDUS health benefit plan. We understand and agree that NDUS is not legally required to extend such benefits to spouses or domestic partners and that NDUS may change or terminate these benefits in it's sole discretion without our consent or the consent of any NDUS member or group of members.

We understand that the information provided in this Affidavit will be treated as confidential by BCBSND but will be subject to disclosure upon the express written authorization of the undersigned Member and/or Domestic Partner, or if otherwise required by law.

We understand and agree that this Affidavit may have legal implications relating to our ownership of property, the taxability of the benefits provided and our personal federal or state tax obligations. We understand and agree that before executing this Affidavit we should seek competent legal and tax advice concerning such matters. We acknowledge and affirm that BCBSND has NOT provided us with any advice in this regard.

We acknowledge and affirm that providing false information or omitting requested information with the purpose of obtaining benefits to which we are not entitled is a violation of law punishable both civilly and criminally. Any Member or Domestic Partner who provides false information to BCBSND or engages in any activity intended to defraud the NDUS health benefit plan may be prosecuted, may result in a civil action being brought against one or both of us to recover any losses incurred (including attorney's fees and costs) and may subject the member to disciplinary action including loss of benefits.

We hereby affirm and certify, under penalty of perjury, that we have read and understood the provisions of this Affidavit, and that all of the information and statements contained herein are true and correct to the best of our knowledge.

_____	_____
(Signature of Student) Date	(Signature of Domestic Partner) Date
_____	_____
Print Name	Print Name
Address:_____	Address:_____
_____	_____
_____	_____
Date of Birth:_____	Date of Birth:_____

Subscribed and sworn before me this _____ day of _____, 20__.

SEAL NOTARY PUBLIC_____

My commission expires: _____

Send completed form to:

Blue Cross Blue Shield of North Dakota, Underwriting Department
4510 13th Ave. S.
Fargo, ND 58121