Affidavit of Domestic Partnership

We, the undersigned, hereby declare that we are domestic partners in accordance with the criteria listed below and have continuously fulfilled such criteria during the immediately preceding twelve (12) months.

Criteria

We are each other's sole domestic partner and intend to remain so indefinitely.
We share a primary residence.
We are emotionally committed to one another, share joint responsibilities for our common welfare, and are jointly responsible for each other's financial obligations as demonstrated by the presentation of two of the following:
a. Joint ownership of real property
b. Common ownership of an automobile
c. Joint bank accounts
d. A will, retirement plan, or life insurance policy designating the other as primary beneficiary
e. A rental agreement showing both parties
f. Driver's licenses showing the same address for both parties
g. IRS tax returns showing the same address for both parties
We are each at least 18 years old and mentally competent to consent to a contract.
We are not related by blood closer than would bar marriage in the State of Florida.
We are not legally married to anyone else.

Change in Domestic Partnership Status

I, the undersigned member, agree to immediately notify Jackson Health Systems when we no longer meet the criteria listed above by filing an 'Affidavit of Termination' form. I understand that upon signing such an Affidavit of Termination, the domestic partner will cease having any status that entitles him or her to be eligible for your health plan administered by Aetna. After such termination, I understand that a subsequent Affidavit of Domestic Partnership cannot be filed until twelve (12) months have elapsed since the date the prior Affidavit of Termination had been signed, provided it has been received by Aetna.

Member's Name: _____ Member's Signature: _____

Domestic Partner's Name: _____ Domestic Partner's Signature: _____

Acknowledgement

By signing below, we have provided this information in the affidavit for use by Aetna and its agents and assigns for the purpose of determining eligibility for and participation in your health plan administered by Aetna by the domestic partner named herein. We affirm, under pain and penalty of perjury, that the information in the affidavit is true and complete to the best of our knowledge. We acknowledge and agree to the terms stated herein, and we understand that any misrepresentation may result in termination of coverage.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

IMPORTANT NOTICE: You are urged to seek appropriate advice before signing this affidavit. There may be other implications to signing this document.

Signatures

Member Information

Print Member's Name: _____

JHS Employee ID#: _____

Member's Signature: _____

Date: _____

Domestic Partner Information

Print Domestic Partner's Name: _____

Domestic Partner's Signature: _____

Date: _____

Name of Employer: _____

Sworn to me this _____ day of _____, 20____

Signature of Notary Public: _____

Seal: _____

Internal Use Only

Aetna Receipt Date: _____

Submit completed affidavit and documents to: VerifyMyJHSDependent@aetna.com