



## DOMESTIC PARTNER AFFIDAVIT

The purpose of this Affidavit is to certify that your partner meets the following Domestic Partnership requirements for the purposes of enrolling your partner as a dependent under your group health plan.

Employee Name \_\_\_\_\_ Identification Number \_\_\_\_\_

Group Name \_\_\_\_\_ Group Number \_\_\_\_\_

A Domestic Partner is defined as a member of a Domestic Partnership consisting of two partners (of the same or opposite sex). In order to qualify for group health coverage, you must meet all of the following requirements:

- |    |                              |                             |  |
|----|------------------------------|-----------------------------|--|
| A. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;                                      |
| B. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is not related to the other party by adoption or blood;  |
| C. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is the sole Domestic Partner of the other partner and has been a member of the Domestic Partnership for at least six (6) months;   |
| D. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Agrees to be jointly responsible for the basic living expenses and welfare of the other partner;   |
| E. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships which are currently enacted, or which may be enacted in the future. |

In addition to the above requirements, evidence of a Domestic Partnership must exist. Verification of one of the following three items will substantiate eligibility for the Domestic Partner under your group health plan.

- Are you and your Domestic Partner registered with a Domestic Partner Registry in effect in the municipality or government entity within which the Domestic Partner currently resides?  
☐ Yes - please list what state you and your Domestic Partner are registered in: \_\_\_\_\_  
☐ No
- Do you and your Domestic Partner currently meet the definition of a Domestic Partner as defined by the state or local government in which you and your Domestic Partner reside?  
☐ Yes - please list what state you and your Domestic Partner reside: \_\_\_\_\_  
☐ No
- As evidence that a Domestic Partnership exists, please attach **two (2) or more** of the following documents to this Affidavit:  
☐ Joint mortgage or lease on the primary residence  
☐ Designation of one of the partners as beneficiary in the other partner's will  
☐ Durable property and/or health care power of attorney  
☐ Joint title to an automobile  
☐ Joint banking account  
☐ Joint credit account

*I certify that the above information is true and correct to the best of my knowledge, information and belief and have provided **the necessary** supporting documents as validation that a Domestic Partnership exists. In the event that the Partnership is dissolved, the employee agrees to immediately notify his/her employer of the change in status.*

*Employee Signature*

Date \_\_\_\_\_

**Return form to: Highmark Underwriting Department  
P O Box 1948  
Parkersburg, WV 26102-1948**

## **Discrimination is Against the Law**

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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 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>.

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

**ATENCIÓN:** Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注: 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.