TUFTS Health Plan

DOMESTIC PARTNER STATEMENT OF ENROLLMENT

I declare and acknowledge that we, _____ and _____ ,
employee (print) domestic partner (print)

are domestic partners in accordance with the following criteria and are eligible for benefits coverage as domestic partners under Tufts Health Plan Associated Health Plans, Inc. , its affiliates and subsidiaries (hereinafter called "Tufts Health Plan") benefits program.

I. ELIGIBILITY:

A. We are at least 18 years of age. (To be covered under your life insurance policy your partner cannot be more than 70 years of age.)

B. We are not married to anyone and we share a mutually exclusive and enduring relationship.

C. We are not blood relatives close enough to prohibit legal marriage.

D. We have shared a common residence for at least 12 consecutive months and intend to do so indefinitely.

E. We attest that shared residency began on _____.

F. We understand that proof, satisfactory to Tufts Health Plan, of 12 consecutive months of shared residence will be requested and verified at the time of enrollment.

G. We consider ourselves life partners and share joint responsibility for our common welfare.

H. We are financially interdependent and have agreed to assume financial responsibility for the welfare of each other.

I. We have not signed a domestic partner affidavit with any other person within the last 12 months.

J. We understand that parents, siblings and roommates are ineligible to be added as a domestic partner.

K. We understand that in order for dependent children of domestic partners to be covered, they must live with us for at least 6 months out of the year and otherwise meet applicable service requirements.

II. CHANGE IN STATUS:

We agree to notify "Tufts Health Plan" Human Resources Department within 30 days if there is any change in our status as domestic partners which would make us no longer eligible for

benefits (for example: death of domestic partner, change in joint-residency). We will notify "Tufts Health Plan" within thirty (30) days of such a change by submitting a Statement of Cancellation. Coverage will end on the date which any of the eligibility are no longer satisfied, or the date coverage ends according to the terms of the plan or federal or Massachusetts law.

III. ACKNOWLEDGMENTS:

A. We understand that the plan document for each plan governs all questions of coverage.

B. We understand that COBRA will be made available to domestic partners and/or their dependents if a family status change (as defined in the policy) occurs.

C. We understand the under the Internal Revenue Code (IRC), the value of benefits coverage for domestic partners and their dependents is considered taxable income to the employee unless the domestic partner and his/her dependents qualify as the employee's tax dependents under IRC. The amount of taxable income is based on the market value of the coverage purchased for these additional family members.

IV. STATEMENT OF CONFIDENTIALITY:

A. Tufts Health Plan will keep information obtained in the Statement of Enrollment in the strictest confidence. Such information will not be used for any other purpose or released without consent.

B. We have provided the information in this Statement of Enrollment for use by "Tufts Health Plan" Human Resources Department for the sole purpose of determining our eligibility for domestic partner benefits and administering domestic partner benefits as necessary.

C. We affirm, under penalty of perjury, that the assertions in this Statement of Enrollment are true to the best of our knowledge.

D. We understand that any misrepresentation may result in the rescinding of coverage, retroactive to the date we initially joined the plan.

_____	_____
Employee Signature	**Street Address**
_____	_____
Date	**City, State, Zip Code**
_____	_____
Domestic Partner Signature	**Street Address**
_____	_____
Date	**City, State, Zip Code**