Affidavit of Domestic Partnership

We, _____ and _____
Employee (print) Domestic Partner (print)
represent, based on our own personal knowledge, that we meet all applicable eligibility requirements under the

UMass Amherst PostDoctoral health insurance plan.
Account Name

In addition, as domestic partners in an exclusive relationship, we acknowledge:

- We are at least eighteen (18) years of age or older and of legal age of consent;
- We are competent to enter into a legal contract;
- We share the same residence and intend to continue to do so;
- We are jointly responsible for basic living costs;
- We are in a relationship of mutual support, caring, and commitment in which we intend to remain;
- We are not married to anyone else; and
- We are not related to each other by adoption of blood to a degree of closeness that would otherwise bar marriage in the state in which we live.

OR

We do not meet the all of the above bulleted criteria but are registered as domestic partners with the state or municipality in which we live.

We affirm, under penalty of perjury, that the assertions in this affidavit are true and accurate to the best of our knowledge. If we misrepresent or provide false information, we agree that our membership may be terminated (including retroactively) at the discretion of Blue Cross and Blue Shield of Massachusetts and/or the Account.

_____ _____
Employee Signature Date

_____ _____
Domestic Partner Signature Date

Notice Requirements

We agree to notify University of Massachusetts Amherst Human Resources within 30 days of any change in our status as domestic partners which would make us no longer eligible for the Account's benefits (for example, a change in joint residence or if we are no longer each other's sole domestic partner) by filing a Statement of Termination of Domestic Partnership ("Statement of Termination"). The Statement of Termination shall affirm that the domestic partnership status is terminated as of its date of execution and that a copy of the Statement of Termination has been mailed to the other party by the party authorizing such action.

Employer Rights

The Account, in accordance with the eligibility requirements of its benefits programs, reserves the right to terminate, modify, or adjust its benefits programs at any time in its sole discretion.

We understand that should the Account or any other person or entity suffer any loss due to any false statement contained in this affidavit they may bring a civil action against either or both of us to recover their losses, including reasonable attorney's fees. Furthermore, we understand that if it is determined that any false statements are contained in this affidavit or we fail to provide updated information as required herein, our health coverage may be terminated upon 60 days notice retroactive to the date this affidavit was signed.

We understand that domestic partners and their eligible dependents are eligible for continuation of coverage rights for health insurance to the extent that legal spouses and their dependents are entitled to such similar rights under federal or state law.

Statement of Termination of Domestic Partnership

1. I, _____ , state the following based upon my own personal knowledge:
   Employee or Domestic Partner (print)

   _____ and I are no longer domestic partners.
   Name of Employee or Domestic Partner

2. I make and file this Statement of Termination in order to cancel the Affidavit of Domestic Partnership, dated _____ .
   Effective Date of Temination

   The above date is within 30 days of the termination of our domestic partnership.

3. I mailed my former domestic partner a copy of this notice at _____
   _____ on _____ .
   Former Domerstic Partner's Address Date mailed

4. I affirm, under penalty of perjury, that the assertions in this statement are true to the best of my knowledge.

Signed: _____ Date: _____

Print Name: _____

Address: _____

_____

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MASSACHUSETTS