University of Massachusetts Amherst

University Health Services

Affidavit of Domestic Partnership

We, _____ and _____
Student (Print) Domestic Partner (print)
represent, based on our own personal knowledge, that we meet all applicable eligibility requirements under University Health Services for Wellfleet Student Health Insurance.

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 University Health Services and/or the Wellfleet Student Health Insurance.

_____
Student Signature Date

_____
Domestic Partner Signature Date