CNMI DEPARTMENT OF FINANCE
GROUP HEALTH & LIFE INSURANCE TRUST FUND
P.O. Box 5234 CHRB, Saipan, MP 96950
Phone: (670) 664-1100 / Fax: (670) 664-1115

AFFIDAVIT OF DOMESTIC PARTERNSHIP FORM

A. EMPLOYEE / RETIREE / SURIVIVING SPOUSE INFORMATION

Last Name, First Name, Middle Initial	Social Security Number	Date of Birth (M/D/Y)	Gender (M/F)

Street or PO Box Address	Home Phone Number	Date Criteria Met

City	State	Zip	Department Name	Division Name	Work Phone Number

B. DOMESTIC PARTNER INFORMATION

Last Name, First Name, Middle Initial	Social Security Number	Date of Birth (MM/DD/YY)	Gender (M/F)

C. DECLARATION OF DOMESTIC PARTNERSHIP

We declare that we are domestic partners, and we meet all of the following criteria:

1. We are both at least eighteen years of age and mentally competent to consent to this contract.
2. We have cohabitated for two or more years.
3. We share the same regular and permanent residence, with the current intent to continue to do so indefinitely.
4. We share a close personal and intimate relationship and are not related by blood closer than would bar marriage in the state in which we legally reside.
5. We assume responsibility for each other's welfare and financial wellbeing.
6. Neither of us is married to another.
7. We are able to provide at least there of the following as verification of our joint responsibility for each other:
    a. Joint mortgage or lease for a residence identifying both parties as responsible for the payment;
    b. Designation of each other as primary beneficiary for life insurance or retirement benefits:
    c. Durable power of attorney for health care or financial management:
    d. Joint ownership of a motor vehicle;
    e. Record of a joint checking account;
    f. Record of a joint savings account;
    g. Record of a joint credit card account;
    h. A relationship or cohabitation contract that obligates each of us to provide support for the other;
    i. Wills specifying the domestic partner as the major recipient of subscriber's financial assets; or
    j. Other forms of evidence depicting significant joint financial interdependency.

D. CERTIFICATION OF DEPENDENT CHILD/CHILDREN OF A DOMESTIC PARTNER

I certify that the child/children of my domestic partner listed below meet the Plan requirements for eligible dependent(s):

Name First, MI, Last	Gender	Date of Birth	SS#

Health benefits coverage for the child/children of my domestic partner listed below meet the Plan requirements for eligible dependents(s);

1. The child meets the eligibility criteria for dependent child(ren)under the provisions of the Plan (an eligible dependent child can be your natural child; legally adopted child; a child place with you for adoption; a child for who you have court documented legal guardianship; a step child living with you in a normal parent/child relationship (or a child for who you have a legal obligation to provide medical insurance); and
2. The child can be , and is claimed as a depended by the Subscriber and/or Domestic Partner for Federal Income Tax purposes; and
3. The Subscriber and his/her Domestic Partner have agreed between themselves to be jointly responsible for the child's welfare; and
4. The child is not married; and
5. The child is under 18 years of age and financially dependent upon you; or
6. The child is over 18 but under 24 years of age, but is a full-time student and financially dependent upon you; or
7. The child is incapable of self-sustaining employment because of a continuing mental or physical disability that existed before the child reached age 18 and the child is financially dependent upon you.

E. ACKNOWLEDGEMENTS – SUBSCRIBER & DOMESTIC PARTNER AUTHOIZATION & SIGNATURE

We understand that:

1. Information provided in this Affidavit is to be used for the purpose of determining our eligibility for benefits and the administration of these benefits. Any other use of this information will be subject to disclosure only upon either our written authorization or as required by law.
2. A civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contain in this Affidavit of Domestic Partnership.
3. Availability of these benefits is based on eligibility requirements and subject to any future change in the Plan's provisions.
4. The Subscriber is responsible for submitting a "Termination of Domestic Partnership" form notifying the Plan within 60 days of when the partnership no longer meets all of the criteria attested to in this declaration. The eligibility for domestic partner (and domestic partner's child/children) coverage ends the last day of the month in which they no longer meet the eligibility requirements.
5. A false declaration of a domestic partnership will result in a retroactive termination of benefits of the domestic partner and domestic partner's eligible child/children in the Plan.
6. The Plan shall be entitled to recover from the Subscriber any expenses for claims process for ineligible individuals.

We certify that:

1. Under penalty of perjury that the foregoing is true and accurate to the best of our knowledge.
2. We have read and understand the eligibility requirements.
3. We understand that this form is not an application for health insurance coverage and that the purpose of this form is to establish the eligibility of person named herein for the coverage period provided under the Government Health Insurance Plan.

Print Name of Subscriber	**Print Name of Domestic Partner**
Signature of Subscriber	**Signature of Domestic Partner**
Date:	**Date:**