



Domestic Partner Coverage Policy (for Same and Opposite Gender) Effective December 2006

Eligible Market

- Employer Groups Size 2-50
- This coverage can be offered on a group specific basis beginning 1/1/2001 for same gender and effective 12/2006 for opposite gender.

Contract language as follows:

Domestic Partner is an enrollee's same gender or opposite gender spousal equivalent, provided the enrollee and the domestic partner:

- a) share the same regular permanent residence; and
- b) are jointly responsible for basic living expenses; and
- c) are not married to anyone and have been each other's sole domestic partners for at least 12 months; and
- d) are each 19 years of age or older; and
- e) are each mentally competent to consent to a contract; and
- f) Have completed the form required by the group health plan sponsor or Plan for coverage of a domestic partner and have agreed to any conditions specified in that form.

After terminating a partnership, there will be a twelve-month waiting period to cover the same partner again or a new partner.

Continuation/Conversion

Domestic partners are treated as all other dependents on the policy. All enrollees will be required to complete continuation before they are eligible for conversion.

Dependent Coverage

Dependent coverage is always included. The contract language is as follows:

An enrollee may also enroll the eligible dependent child(ren) of his or her domestic partner for coverage under this contract, so long as the child meets the definition of an eligible dependent and the domestic partner remains eligible and enrolled.

Employer Responsibility

It is the employer's responsibility to verify eligibility of the domestic partner and to collect the form that is required by the employer. The employer group should use attached form for determining eligibility. The employer is to pass along to HealthPartners these dependents in the same manner that other dependents are (i.e. enrollment form).

Sales Responsibility

Indicate that an employer has added domestic partner coverage in the additional info section of the GDF. Domestic partner coverage may only be added at the time of application or upon renewal of the group.



(Employer's Name) Domestic Partnership Agreement and Affidavit
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The purpose of this affidavit and agreement is to determine eligibility for domestic partner benefits. Once eligibility is determined, enrollment form(s) need to be completed and submitted to your employer's benefits office to secure coverage.

Employees' Name _____ **Social Security #** _____

Domestic Partner's Name _____ **Social Security #** _____

Dependents of Domestic Partner

We, the undersigned, hereby affirm and agree to the following:

- 1) We are domestic partners beginning _____ (date) as defined by the following criteria:
 - ◆ We have a long-term committed relationship of mutual caring and responsibility for each other's Common welfare;
 - ◆ We intend to continue our relationship indefinitely;
 - ◆ We are;
 - Same gender adults or opposite gender adults;
 - Not legally married to another;
 - Each other's sole domestic partner for at least the previous 12 months;
 - At least 19 years of age;
 - Legally capable to enter into a contract; and
 - Not related by blood closer than permitted by marriage law in our state of residence;
 - ◆ We share a residence; and
 - ◆ We are jointly responsible to each other for basic living expenses and have included with this Agreement documentation of at least two of the following:
 - A primary beneficiary designation to each other (e.g. will, life insurance).
 - Health care powers of attorney for medical emergencies.
 - A significant joint asset (e.g., bank account, home, car).
 - A significant joint liability (e.g., loan, credit card, mortgage).

- 2) If we meet all the criteria in Section 1 we will be permitted to enroll in the HealthPartners plan after satisfying the employer waiting period.

- 3) The employee will notify the Benefits Office within 31 days of dissolution of our domestic partnership or failure to comply with criteria listed in Section 1, by completing a change form available at the Benefits Office. The employee may not cover another domestic partner under HealthPartners plan for 12 months following the date of termination of our domestic partnership.



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Employee's Signature _____ Date: _____

Domestic Partner's Signature _____ Date: _____

Notary (*required*)

Subscribed and sworn to before me by said _____ this

_____ Day of _____, 200_____. My commission expires _____.