



Asuris Northwest Health  
 528 East Spokane Falls Boulevard  
 Suite 301  
 Spokane, WA 99202  
 Mail form to: PO Box 1107  
 MS: LC1NW  
 Lewiston, ID 83501-1107

## AFFIDAVIT OF DOMESTIC PARTNERSHIP For Individual Health Benefit Plans

Please complete and submit this form if you are enrolling a domestic partner and the relationship is not a state-registered domestic partnership. This form is not required if you are state-registered domestic partners.

### SECTION I - Statement of Domestic Partnership

Name of Contract Holder _____	ID Number	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
Domestic Partner's Name _____		Date Domestic Partnership Began _____										

I certify that \_\_\_\_\_ and I are domestic partners and that we meet the following criteria:  
Name of Domestic Partner (please print)

- ◆ Each domestic partner is at least 18 years of age;
- ◆ The domestic partners share a close personal relationship and are responsible for each other's common welfare;
- ◆ The domestic partners are each other's sole domestic partner;
- ◆ The domestic partners share the same regular and permanent residence with the current intent to continue doing so indefinitely;
- ◆ The domestic partners are jointly financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and medical expense;
- ◆ Neither domestic partner is legally married to anyone else, nor has had another domestic partnership within the 30 days immediately prior to application;
- ◆ The domestic partners are not related by blood closer than would bar marriage in the state issuing the contract; and
- ◆ Each domestic partner was mentally competent to contract when their domestic partnership began.

### SECTION II - Change in Domestic Partnership

I \_\_\_\_\_ agree to notify Asuris Northwest Health within 30 days of any change in our domestic partnership status that would make the domestic partner no longer eligible under the above criteria, and such notice will be treated as a request for termination of the domestic partnership.  
Name of Contract Holder

I, the contract holder, understand that another Affidavit of Domestic Partnership cannot be filed within 90 days after a request for termination of a domestic partnership has been filed with Asuris Northwest Health.

### SECTION III - Acknowledgment

We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization, in any action involving the enrollment or eligibility of the domestic partner, or if otherwise required by law. We understand that this declaration of responsibility for our common welfare may have legal implications under our State law. We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, arising from a false statement contained in the Affidavit of Domestic Partnership. We also certify under penalty of perjury, under our State laws, that the foregoing is true and correct.

▶	Date	▶	Date
Signature of Contract Holder		Signature of Domestic Partner	

Address \_\_\_\_\_

City, State and ZIP Code \_\_\_\_\_

