DECLARATION OF DOMESTIC PARTNER RELATIONSHIP FORM

INSTRUCTIONS – Use this form to inform the State of Montana Benefit Plan (State Plan) of your domestic partnership and request State Plan coverage for your domestic partner and any associated dependents of your domestic partner.

- This form **must be attached to a Mid-Year Change Form and postmarked or returned within 60 days of the date your domestic partner relationship began** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130.
- You must also attach the following:
  - Proof of a shared residence; AND
  - A copy of mutually-granted powers of attorney or health care powers of attorney; OR
  - A copy of mutual designations of primary beneficiary in wills, life insurance policies or retirement plans.

EMPLOYEE INFORMATION

EMPLOYEE ID# _____ LAST NAME _____ FIRST NAME _____ MI ___

DATE OF BIRTH ____-____-_____

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

DOMESTIC PARTNER INFORMATION

LAST NAME _____ FIRST NAME _____ MI ___

- ❑ Male
- ❑ Female

DECLARATION OF DOMESTIC PARTNERSHIP

We, the undersigned, being of lawful age, attest to the following facts:

1. We are both at least 18 years of age;
2. We share a primary place of residence;
3. Neither of us is legally married to another person;
4. Neither of us is related to the other as a parent, brother or sister, half-brother or half-sister, niece, nephew, aunt, uncle, grandparent, or grandchild;
5. We have a financially-interdependent relationship as evidenced by at least one of the following:
   a. Mutually-granted powers of attorney or mutually-granted health care powers of attorney; or
   b. Designation of each other as primary beneficiary in wills, life insurance policies, or retirement plans;
6. The following are the natural or legally adopted children of one or both of us:
   _____.

READ AND SIGN

I understand and acknowledge the State of Montana Benefit Plan (State Plan) reserves the right to request copies of all of the necessary eligibility documents at any time, any copies retained by the State Plan will be kept confidential. If I fail to provide the copies when requested, I understand State Plan coverage for the named domestic partner, and any dependents associated with the domestic partner, will be immediately terminated.

Notification of Change in or Termination of Relationship

I agree that, if the domestic partner relationship as designated above, no longer exists, I will notify the State of Montana Benefit Plan (State Plan) in a manner set forth by the Health Care & Benefits Division within 60 days of such change.

I affirm that the assertions made herein are true under penalty of prosecution.

Employee Signature:_____Date:_____

Domestic Partner Signature:_____Date:_____

Language Assistance – General Taglines

State of Montana is required by federal law to provide the following information.

- ملوحظة: إذا تكذ تحتدث اذرك اللغة، فإن خدمات المعدسة اللوغةيتتوافر لك ابلمامجن. التصد ريمة 855-999-1063)رقم . 1-855-999-1062 :مبكهافـة الصم والـ
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063）
- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).
- ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).
- 注意事項：日本語を話される場合、無料の言語支援をご利用いただけま.1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください.
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.
- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).
- ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).

State of Montana Non-Discrimination Statement: State of Montana complies with applicable Federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact customer service at 855-999-1062. If you believe that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status you can file a grievance. If you need help filing a grievance, John Pavao, State Diversity Coordinator, is available to help you. You can file a grievance in person or by mail, fax, or email: John Pavao, State Diversity Program Coordinator - Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3984 Email: jpavao@mt.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)