

Declaration of Domestic Partner Relationship

Employee Name _____

Employing Agency/Branch _____

Employee ID# _____

This form must be attached to a State of Montana Employee Group Benefits Plan Enrollment/Change Form.

Partner's Name _____

Male

Female

Declaration

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;
 - 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:

_____ ; _____ ; _____ ;

Proof of a shared residence **and** a copy of the mutually-granted-powers of attorney or health powers of attorney, or a copy of your designation of primary beneficiary in wills, life insurance policies, or retirement plans, must be submitted with this form. Your domestic partner and any qualifying child dependents will not be added to the plan until this documentation is received.

I understand and acknowledge that the State reserves the right to request copies of all of the necessary eligibility documents at any time, and any copies retained by the State will be kept confidential. If I fail to provide the copies when requested, I understand that health benefits coverage for the named domestic partner and the domestic partner's dependent children 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 Employee Benefits Plan in a manner set forth by the bureau within 60 days of such change.

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

Employee Signature

Date

Partner Signature

Date