EPISCOPAL CHURCH MEDICAL TRUST

Domestic Partnership Affidavit

I. DECLARATION

We, _____, and, _____,
(Print Subscriber's Full Name) (Print Partner's Full Name)

represent and affirm, jointly and individually, that we are engaged in a domestic partner relationship in accordance with the following criteria and are eligible for healthcare benefits as Domestic Partners under the health Plan offered by my Participating Group through the Episcopal Church Medical Trust (the "Medical Trust").

II. STATUS

1. We are at least eighteen (18) years of age and mentally competent to enter into a legal contract.
2. We have maintained a legal residence together for the past 12 months and intend to remain so indefinitely.
3. Neither of us is married to or legally separated from anyone else.
4. We are each other's sole Domestic Partner, are two adults who have chosen to share one another's lives in a mutually exclusive partnership that resembles marriage, and intend to remain so indefinitely.
5. We are not in this relationship solely for the purpose of obtaining benefits coverage.
6. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state or jurisdiction in which we legally reside, were we of the opposite sex.

III. CHANGE IN DOMESTIC PARTNERSHIP

1. We agree to notify the Medical Trust if there is any change in our status as Domestic Partners as attested to in this Affidavit, which would affect our eligibility for healthcare benefits (for example, if we cease to reside together or if we are no longer each other's Domestic Partner). We agree to notify the Medical Trust within thirty (30) days of such change by filing a Statement of Dissolution of Domestic Partnership, affirming that the Domestic Partnership status has ended as of its date of execution.

2. After such dissolution, I, _____(Subscriber or Member), understand that a subsequent Domestic Partnership Affidavit may not be filed until any subsequent Domestic Partner relationship meets the criteria specified in Section II of this Affidavit. (The 12 month relationship period specified under Section II may be waived if the subsequent Affidavit is filed for the same Domestic Partner who is signatory to this Affidavit.)

IV. ACKNOWLEDGMENTS

1. We understand that failure to notify the Medical Trust when a Domestic Partnership has been dissolved or the use of false or misleading documents to obtain coverage may have serious legal consequences. If health claims have been paid by the Medical Trust or one of its healthcare vendors as a result of false representations, we understand that the Medical Trust and/or its healthcare vendor will seek reimbursement of those expenses and reserves the right to pursue the matter through civil legal action.

2. We have provided the information in this Affidavit for use by the Medical Trust for the sole purpose of determining our eligibility for Domestic Partnership benefits.

3. We understand that the value of Domestic Partnership benefits coverage may be taxable as income.

4. We understand that some courts have recognized non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing community property and that the filing of this affidavit may have other legal consequences.

5. We understand that even though we may be eligible for healthcare benefits as determined by the Medical Trust's criteria for Domestic Partnerships, healthcare benefits may not be available in every medical market or from every Participating Group.

6. We submit the following copies of two items as proof evidencing our cohabitation and mutual support:

_____ Joint bank account statements
_____ Joint credit card statements
_____ Loan agreement indicating joint obligation
_____ Property Deed
_____ Residential tenants lease
_____ Common public utility or telephone bills

7. We understand that if we are eligible for health care benefits as Domestic Partners, and subject to any other exception to coverage, coverage will commence as of the first of the month following our eligibility determination.

V. STATEMENT

We affirm, under penalty of perjury, that the assertions in this Affidavit are true and correct.

_____	_____
Subscriber Signature	Domestic Partner Signature
_____	_____
Phone Number	Phone Number
_____	_____
Email Address	Email Address
_____	_____
Street Address	Date

_____

City, State, Zip

Witnessed by:

_____

Name and Title of Group Administrator

_____	_____
Signature of Group Administrator	Date