MediExcel Health Plan
Affidavit for Enrollment of Domestic Partner

Section One

I, _____ and _____ are domestic partners, and we:
(*print complete name of subscriber*) (*print complete name of domestic partner*)

- are each eighteen (18) years of age or older;
- share a close personal relationship and are responsible for each other's common welfare;
- are each other's sole domestic partner;
- are not married to anyone nor have had another domestic partner within the prior six months;
- are not related by blood closer than would bar marriage in the State of California;
- share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
- are jointly financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and any other expenses of a domestic partner for which the partner qualified for because of the domestic partnership. (Note: Domestic Partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.).

Section Two

I understand that my domestic partner is eligible for enrollment at the time of my hire or throughout the year based on the same eligibility criteria used for other dependents.

I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in circumstances attested to in this Affidavit.

I agree to provide written notice to my payroll/personnel representative if there is any change of circumstances attested to in this Affidavit within 30 days of the change by filling a Statement of Termination of Domestic Partnership.

Section Three

We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of a willful falsification of information contained in this Affidavit of Domestic Partnership.

We understand that under applicable federal and state income tax law, payments for health coverage of a domestic partner may result in additional imputed taxable income to the employee, with possible withholding from payroll taxes (including income and social security taxes.) Consult your Human Resources department for information.

We understand that, in addition to the eligibility requirements of _____ for domestic partner
(*Name of Employer Group*)
coverage, there are terms and conditions of coverage set forth in the MediExcel Health Plan Group Subscriber Agreement to which we agree to be bound.

We acknowledge that, depending on the health care plan we select, the applicable Group Agreement may include, for example and without limitation, (1) a requirement that each of us arbitrate any and all claims, including malpractice claims, against the health care plan we choose and its related organizations and providers; and (2) the right of the health care plan to terminate coverage on the grounds set forth in the Group Agreement including, without limitation; termination of coverage due to fraud, and misrepresentation of eligibility. By executing this Affidavit, we agree to be bound by the terms and conditions of coverage of the health care plan selected as set forth in the applicable Group Agreement, including the arbitration clause, if any.

We understand that willful falsification of information contained in this affidavit may result in our termination of enrollment by the health care plan which we select for coverage.

We also certify under penalty of perjury under the laws of the State of California, that the foregoing is true and accurate to the best of our knowledge.

_____ _____ _____
Signature of Subscriber *Date* *Date of Birth*

_____ _____ _____
Signature of Domestic Partner *Date* *Date of Birth*

_____
Address *City* *State* *Zip Code*

_____ _____
Signature of Witness *Date*

MediExcel HEALTH PLAN

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