CaliforniaChoice®
Your Health. Your Choice.®

721 South Parker, Suite 200, Orange, CA 92868
(800) 558-8003 • www.calchoice.com

Affidavit of Domestic Partnership

Fax completed form to (714) 558-8000

I, _____ and _____ are domestic
(name of employee) *(name of domestic partner)*

partners and we:

1. are not married under either statutory, common law, or part of another domestic partnership;
2. are both 18 years of age or older; or, if under 18, have a valid court order allowing partnership;
3. share an intimate and committed relationship;
4. agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship;
5. are mentally competent;
6. are not related by blood to a degree of closeness that would prohibit marriage in this state;
7. agree to notify California*Choice*® immediately upon termination of domestic partnership.

Members who are in a same sex partnership or the opposite sex and are over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 60 days of issue; all others must submit a signed Affidavit of Domestic Partnership.

We understand that any persons/employer company/health carrier who suffers any loss because of false statements contained in this Affidavit of Domestic Partnership may have cause to bring a civil action against us to recover their losses.

WE DECLARE UNDER THE PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE STATEMENTS HEREIN ARE TRUE AND CORRECT.

Employee Name

Employee Social Security #

Employee Signature

Date (MM/DD/YYYY)

Domestic Partner Name

Domestic Partner Social Security #

Domestic Partner Signature

Date (MM/DD/YYYY)

Witness Name

Signature of Witness

Date (MM/DD/YYYY)

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