AFFIDAVIT OF DOMESTIC PARTNERSHIP

I,____, submit this Affidavit to the Contractholder and declare to establish____as my Domestic Partner (as definedbelow) for the purpose of applying for coverage under the Blue Cross and Blue Shield of Florida,Inc.'s Contract with the Contractholder.

"Domestic Partner" means a person of the same or opposite sex with whom the employee (herein, Certificateholder) has established a Domestic Partnership.

"Domestic Partnership" means a relationship between a Certificateholder and one other person of the same or opposite sex, who meet all of the following eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely; and

2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside; and

3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership; and

4. the Certificateholder has completed and submitted this notarized Affidavit Of Domestic Partnership to the Contractholder and the Contractholder has approved this Affidavit ofDomestic Partnership.

I affirm that we are Domestic Partners and meet the Domestic Partnership eligibility requirements.

DEPENDENT CHILD(REN) OF DOMESTIC PARTNER - CERTIFICATION

Domestic Partner Dependent Child(ren)

Last Name	First Name	MI
Last Name	First Name	MI
Last Name	First Name	MI
Last Name	First Name	MI

We hereby certify that the above named child(ren) of the Domestic Partnership meet all of the eligibility requirements listed below for coverage under the group health plan.

- The above listed child(ren) reside with us and the Domestic Partner is responsible for the child(ren)'s well-being; or the Domestic Partner is required to provide coverage for the child(ren) by court order; or
- The child(ren) qualifies as the Domestic Partner's dependent(s) for tax purposes under the federal guidelines. (Attach a copy of the federal income tax return); and
- The child(ren) meet and continue to meet the eligibility requirements as outlined in the Dependents Eligibility Class and Extension Of Eligibility For Certain Dependent Children Subsections of the Contract.

I further acknowledge and understand:

I have an obligation to submit to the Contractholder an Affidavit of Termination of Domestic Partnership within 10 days of when Domestic Partnership eligibility requirements are no longer met or within 10 days of the death of my Domestic Partner. Coverage of your Domestic Partner will terminate on the date of death of the Domestic Partner or on the last day of the first month that the Domestic Partner and/or Domestic Partner's eligible dependent child(ren) fails to continue to meet all of the applicable Domestic Partnership eligibility requirements.

Blue Cross and Blue Shield of Florida, Inc. has no legal obligation to extend COBRA benefits to Domestic Partners nor the Domestic Partner's dependent child(ren).

I cannot file another Affidavit of Domestic Partnership for a new Domestic Partner until at least 12 calendar months after a Statement of Death or Termination of Domestic Partnership has been filed.

Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information contained in this Affidavit of Domestic Partnership may result in my being responsible for reimbursement of any expenses paid by BCBSF, or in denial of the claim or cancellation or rescission of coverage under this Contract.

I affirm that the information provided above is true and complete to the best of my knowledge.

______________________________	______________________________
Signature of Certificateholder	Signature of Domestic Partner
______________________________	______________________________
Date	Date
______________________________	______________________________
Signature of Notary Public	Date

(SEAL)