



Affidavit of Domestic Partnership

I. DECLARATION

We, _____ and _____ declare that we are Domestic
Print Member's Name *Print Partner's Name*

Partners in accordance with the following criteria, and have continually fulfilled such criteria during the immediately preceding twelve months.

II. CRITERIA

We further declare that:

1. We are each other's sole Domestic Partner and intend to remain so indefinitely;
2. We share a primary residence
3. We are emotionally committed to one another, share joint responsibilities for our common welfare, and are jointly responsible for each other's financial obligations as demonstrated by the presentation of two of the following:
 - a. joint ownership of real property;
 - b. common ownership of an automobile;
 - c. joint bank accounts;
 - d. a will, retirement plan, or life insurance policy designating the other as primary beneficiary;
 - e. a rental agreement showing both parties;
 - f. driver's licenses showing the same address for both parties; or
 - g. IRS tax returns showing the same address for both parties
4. We are each at least 18 years old and mentally competent to consent to a contract;
5. We are not related by blood closer than would bar marriage in the State of Florida;
6. We are not legally married to anyone else.

III. CHANGE IN DOMESTIC PARTNERSHIP STATUS

I, _____ agree to immediately notify AvMed when we no longer meet the
Print Member's Name
criteria listed in Section II above, by filing an "Affidavit of Termination" form. I understand that upon signing such an Affidavit of Termination, the Domestic Partner will cease having any status that entitles him or her to be eligible for AvMed's HMO Coverage.

After such termination, I, _____ understand that a subsequent Affidavit of
Print Member's Name
Domestic Partnership cannot be filed until twelve months have elapsed since the date the prior Affidavit of Termination had been signed, provided it has been received by AvMed.

Affidavit of Domestic Partnership (continued)

IV. ACKNOWLEDGEMENT

By signing below:

We have provided this information in the Affidavit for use by AvMed and its agents and assigns for the purpose of determining eligibility for and participation in AvMed's HMO by the Domestic Partner named herein.

We affirm, under pain and penalty of perjury, that the information in the Affidavit is true and complete to the best of our knowledge; we acknowledge and agree to the terms stated herein; and we understand that any misrepresentation may result in termination of coverage.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

IMPORTANT NOTE:

You are urged to seek appropriate advice before signing this Affidavit. There may be other implications to signing this document.

Member Information

Print Member's Name

Member Number

Member's Signature

Name of Employer

Date

Partner Information

Print Domestic Partner's Name

Domestic Partner's Signature

Date

Sworn to me this _____ day of _____, 2_____

Signature of Notary Public signature and seal

Internal Use Only:

AvMed Receipt

Date