BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA
EMPLOYEE HEALTH BENEFIT PLAN

AFFIDAVIT OF DOMESTIC PARTNERSHIP

We, _____ and
(Full name of Employee)

_____ certify that:
(Full name of Domestic Partner)

1. We share the common necessities of life.
2. We are not married to anyone.
3. We are not related by blood to a degree of closeness that would prohibit marriage in the State of North Carolina.
4. We are at least eighteen (18) years of age or older.
5. We are mentally competent to consent to contract.
6. We are each other's sole domestic partner and intend to remain so indefinitely, and we are responsible for our common welfare. We share financial obligations and share our primary residence.
7. This relationship has been in existence for a period of at least six (6) consecutive months.
8. Two of the following conditions exist (please check all that apply):

____ A. We have common or joint ownership of a residence (house, condominium, or mobile home).

____ B. We have at least two of the following:
- ____ 1) Joint ownership of a motor vehicle
- ____ 2) Joint checking or savings account
- ____ 3) Joint credit account
- ____ 4) Lease for a residence identifying both partners as tenants

____ C. The domestic partner of the employee has been designated as a primary beneficiary for at least one of the following:
- ____ 1) Employee's life insurance policy
- ____ 2) Employee's retirement plan
- ____ 3) Employee's Last Will and Testament

____ D. A "relationship contract" has been executed that obligates each of the parties to provide support for the other party and provides, in the event of the termination of the relationship, for a substantially equal division of any property acquired during the relationship.

Note: Documentation may be required to prove the existence of any of the above-mentioned items.

9. We understand that domestic partners are subject to the terms and conditions of the Blue Cross and Blue Shield of North Carolina Employee Health Benefit Plan and completion of this affidavit provides an option for domestic partnership benefits.
10. We agree to complete the Termination of Domestic Partnership form and return to BCBSNC Human Resources Benefits Department within 30 days of the termination of our domestic partnership. The Termination of Domestic Partnership form also requires the employee to advise the domestic partner in writing that health insurance coverage is ceasing.
11. After termination with my initial domestic partner, another "Affidavit of Domestic Partnership" cannot be filed until the conditions of an "Affidavit of Domestic Partnership" are satisfied with a subsequent domestic partner or twelve (12) months have passed, whichever is later.
12. We provide the information in this affidavit to be used by Blue Cross and Blue Shield of North Carolina and the Health Benefit Plan for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that this information will be held confidential and will be subject to disclosure, other than stated above, only upon our expressed written authorization or pursuant to a court order.

We affirm, under penalty of perjury, that the ascertainments in this affidavit are true and correct to the best of our knowledge.

_____	_____
Signature of Employee	Signature of Domestic Partner
_____	_____
Employee's Social Security Number	Domestic Partner's Social Security Number
_____	_____
Date	Date
_____	_____
Employee's Date of Birth	Domestic Partner's Date of Birth