Health Net Health Plan of Oregon, Inc.
Health Net Life Insurance Company
13221 SW 68th Pkwy., Ste. 200
Tigard, OR 97223
1-888-802-7001

Non-Registered Domestic Partner Affidavit

Health Net Health Plan of Oregon, Inc.

Section A

I and (name of non-registered domestic partner) ____ are non-registered domestic partners who meet the requirements set forth below in each and every respect.

1. We are not related by blood closer than first cousins.
2. Neither of us is married to anyone else nor have we had another domestic partner within the most recent six months.
3. We share an exclusive and loving relationship that we intend to maintain for the rest of our lives.
4. We share a permanent residence with the intent to continue doing so indefinitely.
5. We maintain joint financial accounts and joint responsibility for basic living expenses, including, but not limited to, food, shelter and living expenses.
6. We are each 18 years of age or older and were mentally competent to consent to a contract when our domestic partnership began.

Section B

In addition, we understand that:

1. Enrollment is permitted only at times specified in the health plan.
2. We are obligated to notify my employer if there is any change that would cause us to fail to meet any requirement attested to in Section A.
3. If we fail to meet any of the requirements attested to in Section A, coverage for my non-registered domestic partner and my partner's children will terminate.
4. If our domestic partnership ends, my partner and any covered children of my partner are not eligible for federally mandated continuation of coverage. Portability coverage will be offered to persons residing in the state of Oregon who meet the qualifications for Portability coverage.
5. If our domestic partnership terminates, I may not file a new Affidavit of Domestic Partnership earlier than six months after I notify my employer that my domestic partnership has ended.
6. Willful falsification of information contained in this affidavit may result in termination of our enrollment in the health plan and could result in a claim for damages for losses, including reasonable attorneys' fees and court costs incurred by the health plan because of such falsification.
7. There are terms and conditions set forth in the group contract of the health plan offered by my employer to which we agree to be bound.

We certify under penalty of perjury under the laws of Oregon, Washington or any other state where this affidavit is executed that the foregoing is true and accurate to the best of our knowledge.

Signature of employee: ____

Printed name of employee: ______________________________ Date: ______________

Signature of non-registered domestic partner: ____

Printed name of non-registered domestic partner: ____________________ Date: ______________

Address: ____

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