

## Affidavit of Domestic Partnership

I, \_\_\_\_\_ (Applicant),  
 certify that \_\_\_\_\_ (Partner) and I reside together and  
 share the necessities of life and intend to do so indefinitely at:

\_\_\_\_\_ (Address)

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| <ul style="list-style-type: none"> <li>• We are of the same sex as each other.</li> <li>• We are each other's sole domestic partner and intend to remain so indefinitely.</li> <li>• Neither of us is married to or in a civil union with anyone.</li> <li>• We are both eighteen (18) years of age or older.</li> </ul> | <ul style="list-style-type: none"> <li>• We are not related to each other by blood so closely that it would bar marriage in the State of Colorado.</li> <li>• We are mentally competent to consent to contract.</li> <li>• We are not parties to a Designated Beneficiary Agreement with any person not a party to this Affidavit.</li> <li>• We are responsible for our common welfare.</li> </ul> |
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We share financial obligations, as demonstrated by the existence of at least two of the following conditions. ***Please check those that apply:***

<input type="checkbox"/> We have common or joint ownership of a residence (house, condominium, mobile home, etc.) in which we reside.	<input type="checkbox"/> My domestic partner has legally adopted my dependent child(ren).
We share at least two of the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> Joint ownership of a motor vehicle</li> <li><input type="checkbox"/> Joint checking account</li> <li><input type="checkbox"/> Joint credit account</li> <li><input type="checkbox"/> Residential lease identifying both partners as tenant</li> </ul>	My domestic partner has been designated as a primary beneficiary of at least one of the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> A life insurance policy on my life</li> <li><input type="checkbox"/> My retirement account (401k, IRA, SEP, etc.)</li> <li><input type="checkbox"/> My will</li> </ul>

Within 30 days of the end of our domestic partnership or no longer meeting at least two of the conditions above, we agree to:

- Provide RMHP with a STDPS\* affirming that:
  - ✓ The domestic partnership has been ended, and
  - ✓ A copy of the STDPS has been mailed to the other domestic partner.

We understand that another Affidavit of Domestic Partnership cannot be filed until two (2) years after a STDPS of the most recent domestic partnership has been filed with RMHP.

We provide the information in this affidavit to be used by RMHP for the purpose of determining our eligibility for benefits. RMHP will treat this information confidential as the law allows.

We understand that any person or organization that suffers any loss because of intentional false statements contained in this affidavit may:

- Bring a civil action against us to recover losses, including attorney fees.
- In the event intentional false statements of material facts are contained in this affidavit, RMHP may terminate eligibility for coverage of domestic partner benefits retroactively for all of the following:
 

◆ Primary applicant	◆ his or her domestic partner	◆ the dependent children of either the Primary applicant or domestic partner
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***We affirm that the facts in this affidavit are true to the best of our knowledge:***

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Domestic Partner \_\_\_\_\_ Date \_\_\_\_\_

NOTE: Federal, state, and local regulations concerning the taxability of certain benefits for domestic partners may vary from the regulations concerning the taxability of benefits extended to spouses. Individuals wishing to utilize benefits available to domestic partners are advised to consult their own tax counsel on such matters.

\* Statement of Termination of Domestic Partner Status

## Multi-Language Insert

<b>English</b>	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-346-4643 (TTY: 711).
<b>Spanish</b>	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (TTY: 711).
<b>Vietnamese</b>	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-346-4643 (TTY: 711).
<b>Chinese</b>	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-346-4643 (TTY: 711)。
<b>Korean</b>	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-346-4643 (TTY: 711)번으로 전화해 주십시오.
<b>Russian</b>	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-346-4643 (телетайп: 711).
<b>Amharic</b>	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-346-4643 (መስማት ለተሳናቸው: 711)።
<b>Arabic</b>	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 3464 --643-008-1 (رقم هاتف الصم والبكم: 117).
<b>German</b>	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-346-4643 (TTY: 711).
<b>French</b>	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-346-4643 (ATS : 711).
<b>Nepali</b>	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-346-4643 (टिटिवाइ: 711) ।
<b>Tagalog</b>	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-346-4643 (TTY: 711).
<b>Japanese</b>	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-346-4643 (TTY:711) まで、お電話にてご連絡ください。
<b>Cushite/Oromo</b>	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-346-4643 (TTY: 711).
<b>Persian</b>	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 3464-643-008-1 (117:YTT) تماس بگیرید.
<b>Ibo/Igbo</b>	Ige nti: O buru na asu lbo asusu, enyemaka diri gi site na call 1-800-346-4643 (TTY: 711).
<b>Kru-Bassa</b>	Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̩ [Bàsóò-wùdù-po-nyò] jũ ní, níí, à wuɖu kà kò dò po-poò b̩éin m̩ gbo kpáa. Đá 1-800-346-4643 (TTY: 711)
<b>Yoruba</b>	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-346-4643 (TTY: 711).



## Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, sexual orientation, or gender identity. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, sexual orientation, or gender identity.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters (remote interpreting service or on-site appearance)
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters (remote or on-site)
  - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, sexual orientation, or gender identity, you can file a grievance with: the RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643, or [eeoofficer@rmhp.org](mailto:eeoofficer@rmhp.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the RMHP EEO Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.