



Cigna HealthCare

Affidavit of Domestic Partnership

The undersigned, being duly sworn, depose and declare as follows:

We are each eighteen years of age or older and mentally competent.

We are not related by blood in a manner that would bar marriage under the laws in the State we reside.

We have a close and committed personal relationship and we are each other's sole domestic partner not married to or partnered with any other spouse, spouse equivalent or domestic partner.

For at least one year we have shared the same regular and permanent resident in a committed relationship and intend to do so indefinitely.

We have provided true and accurate required documentation of our relationship.

Each of us understands and agrees that in the event any of the statements set forth herein are not true the insurance or health care coverage for which this Affidavit is being submitted may be rescinded and/or each of us shall jointly and severally be liable for any expenses incurred by the employer, insurer or health care entity.

Print Name

Print Name

Signature

Signature

Sworn to before me this _____ day of _____, 20_____.

Notary Public