Wellmark

Wellmark Blue Cross Blue Shield of Iowa
Wellmark Blue Cross Blue Shield of South Dakota

Independent Licensees of the Blue Cross and Blue Shield Association

CONFIDENTIAL

CERTIFICATION OF DOMESTIC PARTNERSHIP

We, _____, and
(Print Name of Contract Holder)

_____ certify and
(Print Name of Domestic Partner)

declare that we are domestic partners in accordance with the following criteria.

1. We are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for our common welfare.
2. We agree to financially support each other during the time of our domestic partner relationship by being jointly responsible for each other's necessities, including without limitation, food, clothing, housing and medical care.
3. We are at least eighteen (18) years of age or older and are mentally competent to consent to this contract.
4. We are not related by blood closer than would bar marriage in our state of residence.
5. We are not legally married to anyone.
6. This relationship has been in existence for a period of at least twelve (12) consecutive months, and we have jointly shared the same residence for at least six (6) months.
7. Our relationship meets at least three of the following four conditions (please check those that apply A-D)

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

   B. ☐ We have at least two of the following (please check which two apply):

      ☐ Joint ownership of a motor vehicle

      ☐ Joint checking account

      ☐ Joint credit account

      ☐ Lease for a residence identifying both partners as tenants.

   C. ☐ The Domestic Partner has been designated as <u>the primary</u> beneficiary for at least one of the following (please check which one applies):

      ☐ The Applicant's life insurance contract

      ☐ The Applicant's will

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

I declare that I represent and warrant that the facts above are true, and my Domestic Partner and I give Wellmark Blue Cross and Blue Shield, its affiliates, and representative's permission to conduct whatever inquiry they may deem necessary into the facts as stated above. We understand that the purpose of obtaining this information is to establish the eligibility of persons named herein for the coverage provided under Wellmark Blue Cross and Blue Shield. I declare that I have read and accept the terms and conditions provided on the next page.

_____ _____/_____/_____

(Signature of Contract Holder) (Date Signed)

TERMS & CONDITIONS OF DOMESTIC PARTNERSHIP

I. CHANGE IN DOMESTIC PARTNERSHIP

1. We agree to notify Wellmark Blue Cross and Blue Shield if there is any change in our status as domestic partners as attested in this certification which would make the domestic partner and/or any of his/her dependent children ineligible for the Wellmark Blue Cross and Blue Shield Health Plan (for example, due to death of the partner, a change in joint residence, termination of the relationship, etc.).
2. We agree to notify Wellmark Blue Cross and Blue Shield within 31 days of such change in our status as domestic partners and/or dependents by filing a Termination of Domestic Partnership Certification. Coverage under Wellmark Blue Cross and Blue Shield will be terminated as of the end of the month of the date of change in our status as domestic partners and/or dependents.
3. After termination of the Domestic Partnership, another Domestic Partnership Certification cannot be filed until twelve (12) months have elapsed after which I may enroll my Domestic Partner in my health insurance subject to Wellmark Blue Cross and Blue Shield's eligibility and enrollment rules.
4. We understand that when I enroll in health insurance and/or dental insurance my benefit elections will remain in effect until the end of the policy year and I will not be able to make any changes until the next open enrollment period unless I experience a qualified event.

II. HEALTH CARE BENEFITS FOR GROUP COVERAGE

The information provided in this section is applicable if your coverage is provided as part of your employee benefits through your employer.

1. Your group offers its employees the ability to provide benefits for Domestic Partners under the group health plan.
2. Please be aware that as part of its commitment to providing health care coverage to Domestic Partners, your group must comply with federal regulations and guidelines. In Letter Ruling 9603011, the Internal Revenue Service ruled that an employer could not provide health insurance coverage on a tax free basis for domestic partners of an employee unless the Domestic Partner qualified as a dependent of the employee or as a spouse under state law. This letter ruling and applicable law is subject to change without notice.
3. Children of you or your Domestic Partner may be covered under any of the health care options providing they meet the guidelines.
4. Federal regulations regarding the continuation of coverage following terminations will apply. If your Domestic Partner and/or partner's dependents health coverage is canceled as a result of certain circumstances, including but not limited to:
    - the termination of your employment;
    - the ending of the Domestic Partner relationship;
    - or loss of dependent eligibility status;

    then the individual who loses the coverage is eligible to continue the coverage on a voluntary basis under coverage continuation provisions for a specified period of time depending upon the reason for the loss of coverage. You must notify your employer within 31 days of the event. Your employer will then notify the individuals involved of their particular rights under the coverage continuation provisions.

III. ACKNOWLEDGEMENTS

1. We understand that any person, employer or company who suffers any loss due to any false statement contained in a "Domestic Partnership Certification" may bring civil action against either or both of us to recover their losses, including reasonable attorney's fees.
2. We provide the information in this certification to be used by Wellmark Blue Cross and Blue Shield 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 only upon our expressed written authorization, pursuant to a court order or if there is a compelling business need to have access to the information.
3. We understand that this Domestic Partnership Certification may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this certification, we should seek competent legal and accounting advice concerning such matters.
4. We affirm, under penalty of perjury, that the statements in this certification are true to the best of our knowledge.

Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

CONFIDENTIAL

NOTICE OF TERMINATION OF DOMESTIC PARTNERSHIP

I, the undersigned, certify that _____

and I are no longer domestic partners; and I have notified my former domestic partner in writing of the termination on

_____/_____/_____.
(Date)

_____
Signature

_____/_____/_____
(Date)