Affidavit for Domestic Partnership Benefits

We, _____ and _____,
affirm all of the following:

(1) We are the sole domestic partner of the other;

(2) We are 18 years of age or older;

(3) Neither of us is legally married;

(4) We are not related by blood in a manner that would bar legal marriage if we were not of the same gender;

(5) We have lived together at the same regular and permanent residence for the past 6 consecutive months and submit this affidavit as proof. We agree to provide additional written proof that we meet this residency requirement, if required to do so, and understand that a failure to provide such proof could result in loss of coverage;

(6) If, at any time, we terminate our domestic partnership (i.e., any of the statements above cease to be true), we agree to notify Total Health Care USA within 30 days of termination;

(7) We understand that we may not file another affidavit for domestic partnership benefits to establish a new domestic partnership until at least 6 months after termination of this domestic partnership; and

(8)* We are financially interdependent.

Date: _____ Employee Signature: _____

Subscribed and sworn to before me this ___ day of _____, 20__

Notary Public, _____ County, Michigan.

My Commission Expires:_____

Date: _____ Domestic Partner Signature: _____

Subscribed and sworn to before me this ___ day of _____, 20__

Notary Public, _____ County, Michigan.

My Commission Expires:_____

* Applies to THC USA members/Domestic Partners only.