CITY OF STARKVILLE
RECOMMENDATION FOR BOARD ACTION

AGENDA ITEM NO:
AGENDA DATE: 09-16-2014
PAGE: l

SUBJECT: DISCUSSION AND CONSIDERATION OF THE HEALTH INSURANCE FOR THE CITY OF STARKVILLE RELATED TO PLUS ONE COVERAGE.

AMOUNT & SOURCE OF FUNDING:

FISCAL NOTE: N/A

REQUESTING DEPARTMENT:

DIRECTOR'S AUTHORIZATION:

FOR MORE INFORMATION CONTACT:

AUTHORIZATION HISTORY:

SUGGESTED MOTION:

AFFIDAVIT OF DOMESTIC PARTNERSHIP

I. DECLARATION

_____ and _____
Employee (print) Domestic Partner (print)

Certify that we are domestic partners in accordance with the criteria identified in Section II. Status (below) and are eligible for benefit coverage as domestic partners under the coverage provided by Blue Cross Blue Shield of MS or its affiliates and subsidiaries.

II. STATUS

The employee and domestic partner represent that they meet each of the identified criteria and agree to provide evidence as requested attesting that the following eligibility requirements are met:

1. We are each other's sole domestic partner and intend to remain so indefinitely.
2. We are of the (opposite or same) sex and neither of us is married to someone else.
3. We are at least eighteen (18) years of age and mentally competent to consent to contract.
4. We are not related by blood to a degree of closeness that would prevent legal marriage in the state in which we legally reside.
5. We reside together in the same residence and have done so continuously for the past 12 months and intend to do so indefinitely.
6. We are jointly responsible for each other's common welfare and financial obligations, and we attach to this Affidavit evidence thereof a document which reflects our joint financial responsibilities, (e.g., copy of morgages, leases). City of Starkville and BCBSMS may reasonably request, as necessary, other documentation that reflects our joint financial responsibilities.

III. CHANGE IN DOMESTIC PARTNERSHIP

We agree to notify our employer within thirty (30) days if there is any change in our status as domestic partners, including the information attested to in this Affidavit which would make us no longer eligible for employee or domestic partner coverage or where we no longer meet one or more of the requirements of Section II. Status.

IV. ACKNOWLEDGEMENTS

We understand and agree that if the employer suffers any loss due to any false statement contained in this Affidavit, it may bring a civil action against either or both of us to recover its losses, including reasonable attorney fees. We understand and agree that the employer may (1) terminate the coverage of the employee or domestic partner if that individual does not meet the eligibility requirements of the coverage provided by employer or the criteria identified in this Affidavit or (2) rescind our health care coverage back to the effective date of our coverage if the employer concludes one or both of us made fraudulent representations in this Affidavit.

- We have provided the information in this Affidavit for use by our employer and Humana for the purpose of determining our eligibility for domestic partner coverage.

- We affirm, under penalty of perjury, that the representations made in this Affidavit are true to the best of our knowledge.

_____ _____

Employee Signature **Date**

_____

_____

Employee Address

_____ _____

Domestic Partner Signature **Date**

_____

_____

Domestic Partner Address

STATE OF MISSISSIPPI
COUNTY OF OKTIBBEHA

GIVEN UNDER MY HAND AND OFFICIAL SEAL on this _____ day of _____, 2014.

(S E A L)

_____
NOTARY PUBLIC

My Commission Expires:

_____