SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Domestic Partnership Statement/Enrollment Application

Domestic Partner Statement

This Domestic Partnership Statement establishes the eligibility of the domestic partner named below for benefits under the coverage issued by Security Health Plan.

Eligible employee _____ Domestic partner _____

We, the undersigned, attest that all of the following are true:

- Neither party is married to anyone nor has another domestic partner
- We are not related by blood closer than would bar marriage in the state of our residence
- We are both of age for legal marriage
- We occupy the same dwelling unit
- The relationship is not temporary, social, political, commercial or economic in nature
- We have had a relationship for at least 12 months

In addition we will provide to the employer/policyholder documentation/proof that, for at least a 12-month period, we either:

- Have obtained a domestic partnership certificate from the city or state, or from any other city, county or state offering the ability to register a domestic partnership; or
- Have any three of the following:
  - ☐ Joint lease, mortgage or deed
  - ☐ Joint ownership/lease of a vehicle
  - ☐ Joint ownership of checking account or credit account
  - ☐ Designation of the domestic partner as a beneficiary of the eligible employee's will
  - ☐ Designation of the domestic partner as a beneficiary for the eligible employee's life insurance or retirement benefits
  - ☐ Designation of the domestic partner as holding power of attorney for health care
  - ☐ Sharing of household expenses

Indicate here the earliest date upon which your domestic partnership fulfilled all of the conditions described above _____ /_____ /_____ (month/day/year)

Note that the domestic partner is eligible for coverage on the later of these two dates:

- the date upon which the employee is first eligible for coverage
- the earliest date upon which the domestic partnership fulfilled all of the conditions described above

The eligibility date is meaningful because it is important for the Eligible Employee to apply for the domestic partner's coverage within 30 days of that date. If he or she doesn't, the policy's rule for late enrollment will apply.

We agree to notify Security Health Plan and Policyholder within 30 days of the date of any change in our status as domestic partners.

We understand that this form with our signatures is part of the contract of insurance and Security Health Plan has the right to verify the information contained herein at any time.

We understand that the federal and state governments do not recognize domestic partners as spousal equivalents for purposes of the laws/rules governing the taxation and other aspects of employee benefits. For example, premiums or parts of premium paid by the policyholder in excess of the amount that would otherwise be paid for the employee's coverage may be considered income to the employee.

We acknowledge that Security Health Plan has no responsibility with respect to any legal obligations we may be subject to as a result of the attestations in this statement and/or the benefits themselves.

We declare under penalty of perjury that the above statements are true and correct. We understand that misrepresented, false, inaccurate, or misleading information, including failure to provide updated information, may result in retroactive termination of coverage. We also understand that if coverage is terminated retroactively, we will be required to repay any benefits provided by Security Health Plan while relying on this document.

_____	_____
Eligible employee signature	Domestic partner signature
_____ ____ /_____ /____	_____ ____ /_____ /____
Eligible employee name (print or type) Date (m/d/y)	Domestic partner name (print or type) Date (m/d/y)

Notice of Nondiscrimination

Security Health Plan of Wisconsin, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status.

Limited English Proficiency Language Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY: 711).

SecurityHealth Plan℠

Promises kept, plain and simple.®

Enrollment Application (Addendum to Application for Group Health Insurance)

Applicant Information

Date partnership began _____ /_____ /_____

Name _____ Date of birth _____ /_____ /_____
Last First M.I.

Domestic Partner Information

Name _____ Date of birth _____ /_____ /_____
Last First M.I.

Domestic Partner's Children (applies only if policyholder/employer has elected this coverage option)

Name _____ Date of birth _____ /_____ /_____
Last First M.I.

Name _____ Date of birth _____ /_____ /_____
Last First M.I.

Name _____ Date of birth _____ /_____ /_____
Last First M.I.

Name _____ Date of birth _____ /_____ /_____
Last First M.I.

Name _____ Date of birth _____ /_____ /_____
Last First M.I.

Name _____ Date of birth _____ /_____ /_____
Last First M.I.

Other Coverage

Is the domestic partner or the domestic partner's children covered by any other health insurance: ☐ Yes ☐ No

If yes, name of insurance company _____

Policy number _____ Effective date _____

Medicare Information

Is the domestic partner receiving Medicare: ☐ Yes ☐ No

If yes, Medicare claim no. _____ Eff. date Part A _____ Eff. date Part B _____

(Domestic partner and children (age 18 or older) need to complete an Authorization to Use and Disclose Protected Health Information form. Domestic partner should sign on spouse's signature line.)