ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC.

Declaration of Domestic Partnership

Employee Name_____ Social Security #_____

Please specify the requested information for your eligible Domestic Partner:

Name _____

DOB_____

SSN _____

Eligibility

As an employee of _____ who is eligible for medical insurance coverage, I certify that the above-identified person meets the following criteria for an eligible Domestic Partner. (Documentation demonstrating the criteria is required to be attached):

- ❑ Is at least 18 years of age;
- ❑ Has proof of joint ownership or joint tenancy for at least the most recent twelve (12) consecutive months, during which the jointly-owned or jointly-leased residence has served as the primary place of residence for the Employee and Domestic Partner;
- ❑ Does not meet the legal definition of spouse or the Allegiance Life & Health Insurance Company, Inc. Policy definition of dependent child;
- ❑ Does not have a parental relationship with you;
- ❑ Is not related to you by blood or marriage;
- ❑ Has provided evidence of at least **three** of the following with the above named Employee:
  - ❑ Joint ownership or lease of one or multiple motor vehicles;
  - ❑ At least one joint liability such as a loan, credit card, or automobile or property insurance coverage.
  - ❑ Mutually-granted powers of attorney or mutually-granted health care powers of attorney;
  - ❑ Designation of each other as primary beneficiary in wills, life insurance policies, or retirement annuities.
  - ❑ Holding one or more bank accounts jointly such as a checking or savings account in both names.
  - ❑ Other proof of financial interdependence as approved by Allegiance Life & Health Insurance Co., Inc.

Notification of Change in or Termination of Domestic Partner

I agree that if the Domestic Partnership as designated above no longer exists, I will notify Allegiance Life & Health Insurance Company, Inc. in writing within 30 days of such change.

Certification

I understand all of the following:

1. The eligibility and coverage of a Domestic Partner will cease at the end of the month in which any of the above-defined criteria are no longer met;

2. Under federal and state law, benefit coverage of a Domestic Partner may result in taxable income to the employee and may be subject to income tax withholding and applicable payroll taxes;

3. Coverage for an eligible Domestic Partner may only be activated during open enrollment;

4. Allegiance Life & Health Insurance Company, Inc. must be given written notice within thirty (30) days of any change in circumstances attested to in this document;

5. Falsely certifying eligibility for Domestic Partner coverage or failing to inform Allegiance Life & Health Insurance Company, Inc. of a relevant change in eligibility requirements in any respect may result in cancellation of coverage and other legal consequences as allowed by applicable law; and,

6. The Employee may be liable for all expenditures for coverage and benefits obtained because of any misrepresentation or omission in certifying eligibility for benefits or in failing to inform Allegiance Life & Health Insurance Company, Inc. of a change in eligibility criteria.

I further understand and acknowledge that Allegiance Life & Health Insurance Company, Inc. reserves the right to require copies of any or all of the above-listed documents. If I fail to provide the copies when requested, I understand that medical insurance coverage for the named Domestic Partner will be immediately terminated.

I affirm that the statements made herein are true and correct to the best of my knowledge.

_____

Employee Signature Date

AFFIRMATION

State of _____)
: ss.
County of _____)

On this _____ day, of _____, 20___, before me, a notary public, personally appeared _____, who made known to me to be the person who executed the within affirmation and acknowledged to me that he/she executed the same for the purposes therein stated.

_____
Signature of Notary Public

(seal)

_____
Printed Name
Residing at _____
My Commission Expires:_____