



# BlueCross BlueShield of Vermont

*An Independent Licensee of the Blue Cross and Blue Shield Association.*

## STATEMENT OF DOMESTIC PARTNERSHIP

**Note to Group: Keep a copy of this document for your records and forward the original Statement attached to an appropriate Group Application and Change Form.**

### Group

Number \_\_\_\_\_

Name \_\_\_\_\_

### Employee

Name \_\_\_\_\_ Identification # \_\_\_\_\_

Home Address \_\_\_\_\_ Social Security # \_\_\_\_\_

Birth Date \_\_\_\_\_

### Domestic Partner

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_ Birth Date \_\_\_\_\_

\_\_\_\_\_

### We the undersigned attest to the following:

- each party is the sole domestic partner of the other;
- each party is at least eighteen (18) years of age or older and competent to enter into a contract in the state in which he or she resides;
- both parties currently share a common legal residence and have shared said residence for at least six (6) months prior to application for domestic partner coverage;
- neither party is married, a party to a Civil Union, or related to the other by adoption or blood to a degree of closeness that would bar marriage/Civil Union in the state in which they legally reside;
- both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
- the parties are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household; the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

### SWORN STATEMENT

We declare that all the foregoing information provided by us is true and correct and that all provisions of this Statement have been met.

### We understand that:

- any entities or persons (including, but not limited to, Blue Cross and Blue Shield of Vermont) who suffer any loss because of any false statements contained in this Statement may bring a civil action suit against us to recover their respective losses, including reasonable attorney's fees;
- if there is any change in the information certified in the Statement of Domestic Partnership that would make the domestic partner ineligible, the employee must complete and file a Termination of Domestic Partnership form within 30 days of the changes; and



## NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator  
Blue Cross and Blue Shield of Vermont  
PO Box 186  
Montpelier, VT 05601  
(802) 371-3394  
TDD/TTY: (800) 535-2227  
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of  
Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
(800) 368-1019  
(800) 537-7697 (TDD)

Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).



## For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583

CHINESE

如需免費語言協助服務，請致電 (800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

नःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevodjenja, pozovite na broj (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

We'll see you through.

(800) 255-4550 | [www.bcbsvt.com](http://www.bcbsvt.com)



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