

Same-Sex Domestic Partner Statement

We, _____ (Employee) and _____ (Named Partner), for the purpose of establishing Same-Sex Domestic Partner status for TeamHealth health, dental and vision benefit coverage (not including COBRA) attest and agree as follows:

1. We each attest that we are sole Same-Sex Domestic Partners, with a close and personal relationship with one another, in accordance with the following:
 - We are responsible for each other’s welfare and intend to remain so indefinitely;
 - We are financially interdependent;
 - We have resided together continuously for at least (12) months before the date of this Statement, and are living together now, and intend to do so indefinitely;
 - We are at least eighteen (18) years of age and legally competent to contract;
 - We are not acting under force or duress;
 - Neither of us is married to or legally separated from any other person;
 - We are not related to one another by blood; and
 - Neither of us has signed a Same-Sex Domestic Partner Statement as partner of anyone else during the twelve (12) months prior to the date of this Statement.
2. We understand that:
 - TeamHealth reserves the right to request documentation or other proof that our Same-Sex Domestic Partner status meets the eligibility criteria set forth in Section 1 and will provide the supporting documentation if requested to do so and TeamHealth, in its sole discretion, has the final determination of Same-Sex Domestic Partner status.
 - We understand that eligibility for coverage of the domestic partner’s dependent children will be determined under the same standards as eligibility that applies to the children of an employee’s spouse.
3. If our Same-Sex Domestic Partner status changes as attested to in Section 1, benefit coverage provided under TeamHealth Benefits for the Named Partner will terminate and:
 - The employee shall notify TeamHealth in writing of the change in Same-Sex Domestic Partner status within thirty days of such change by completing a Termination of Same-Sex Domestic Partnership Statement.
 - We understand that for a period of twelve (12) months following termination of our Same-Sex Domestic Partner status;
 - i. Neither of us can file another Same-Sex Domestic Partner Statement with TeamHealth;
 - ii. No other person will be eligible under the Policy as a Same-Sex Domestic Partner of the Employee; and
 - iii. The Named Partner hereunder will not be eligible under the Policy as a Same-Sex Domestic Partner of any other employee of TeamHealth.

We understand that this information has been provided for the sole purpose of establishing eligibility under TeamHealth Benefits as Same-Sex Domestic Partners. This information will be held confidential and will be subject to disclosure only upon our written authorization or if otherwise required by law.

I, the undersigned employee, understand that willful falsification of information on this Statement may lead to disciplinary action, up to and including discharge from employment.

Employee Signature _____

Named Partner Signature _____

Social Security # _____

Social Security # _____

Address _____

Address _____

Date _____

Date _____