Declaration of Domestic Partnership (Texas)

I, (print name of employee) _____, certify that I and (print name of domestic partner) _____ are and have each been the other's partner in a domestic partnership, as defined below.

For purposes of this document, a "domestic partnership" is one consisting of two persons in which they:

1. Jointly shared the same permanent residence for at least six (6) months immediately preceding the date of this declaration and intend to continue to do so indefinitely;
2. Have a close personal relationship with each other;
3. Are not legally married to or in a registered domestic partnership with anyone;
4. Are each eighteen (18) years of age or older;
5. Are not related to each other by blood in a degree of kinship closer than would bar marriage in the State of Texas;
6. Were mentally competent to contract when the domestic partnership began;
7. Are each other's sole domestic partner;
8. Are jointly responsible for each other's common welfare including "basic living expenses." For purposes of this document, "basic living expenses" means the cost of basic food, shelter, and any other expenses for which the partner qualified because of domestic partnership. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost; and
9. Meet the definition of domestic partner as set forth in the Member Handbook, if applicable.

This Declaration of Domestic Partnership terminates upon the death of the employee's domestic partner or by a change in circumstances attested to in this document. Within thirty (30) days after such death or change(s) in circumstances, the employee must submit a letter documenting the termination of domestic partnership to the employer. After submitting such letter, the employee may not file a new Declaration of Domestic Partnership to enroll a new domestic partner for six (6) months from the date the letter of termination is received by the employer.

Notice: Signing this document may or may not have legal implications affecting relations between domestic partners beyond the extension of medical insurance coverage for which it is intended. If you desire further information concerning the possible legal consequences of signing this form, please consult an attorney.

I attest that the certification I have provided herein is true and correct to the best of my knowledge.

Employee signature X	Date (mm/dd/yyyy)
Received by (group administrator)	Date (mm/dd/yyyy)

Ready to submit? Mail this form to Moda Health

601 SW Second Avenue, Portland, OR 97204

Questions? We're here to help. Contact our Customer Service Department.
For medical: 844-931-1779 (TTY users, dial 711.)

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