



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 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...
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 a motor vehicle;
At least one joint liability such as a loan or credit card;
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.

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., 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;

