



This form must be returned 31 days from the date printed on your Confirmation Statement. If this information is not received, coverage for your Domestic Partner will be terminated retroactive to the coverage effective date. Please return original document to Caremark Benefits Center, 2211 Sanders Rd. NBT-9, Northbrook, IL, 60062 or interoffice mail to: mail code NBT-9.

I, _____
 Print Employee's Name Social Security Number

AND

I, _____
 Print Partner's Name Social Security Number

Declare under penalty of perjury that we are domestic partners within the meaning of the following declaration:

1. We have an intimate, committed relationship of mutual caring and intend to remain sole domestic partners indefinitely; and,
2. We share the same principal residence; and,
3. We agree to be responsible for each other's basic living expenses during our domestic partnership such as food, shelter, or medical expenses; we also agree that we share financial obligations and any third party who is owed these expenses can collect from either of us; and,
4. We are both 18 or older; and,
5. Neither of us is married; and,
6. We are of the same sex; and,
7. We are not related by blood to the other such as a parent, brother, sister, half brother, half sister, niece, nephew, aunt, uncle, grandparent, or grandchild; and
8. Neither of us has a different domestic partner now; and,
9. Neither of us has had a different domestic partner or spouse in the last six (6) months unless a previous domestic partnership terminated by death.

Each of us agrees to immediately notify the Caremark Benefits Center within 31 days in writing if there is any change of circumstances attested to in this Affidavit.

Each of us understands that domestic partners are eligible for enrollment only if the employee is newly eligible for benefits or during annual enrollment.

Each of us understands that the premium charged for the selected coverage(s) will be deducted on a post-tax basis and the company portion will be recorded as imputed income on the employee's W-2.

Each of us understands that the domestic partner does not have rights to continuing coverage under federal law through COBRA.

Each of us understands the rules of the plan and declares under penalty of perjury under the laws of the state of residence that the statements we have made here are true and correct.

Notarized Signatures Required

 Employee's Signature Date

 Partner's Signature Date

State County Signed before me on this day of , 20

The undersigned Notary Public personally appeared, personally known to me, provided to me on the basis of satisfactory evidence to be the person(s) whose name(s)

subscribed to the within instrument, and acknowledged that _____ executed it.

WITNESS my hand and official seal,

 Notary's Signature Date Notary Seal