



# MIT Health Plan

## Affidavit of Spousal Equivalent Partnership for Eligibility for Student Health Plan or Affiliate Health Plan

### I. Declaration

We, \_\_\_\_\_ and \_\_\_\_\_  
Student or Affiliate (print) Spousal Equivalent (print)

certify that we are spousal equivalent partners in accordance with the following eligibility criteria and that we are eligible for coverage under the MIT Student Health Plan or MIT Affiliate Health Plan.

### II. Eligibility Criteria

The student or affiliate and spousal equivalent partner must attest to the following eligibility requirements.

1. We are each other's sole domestic partner and intend to remain so indefinitely.
2. Neither one of us is married to someone else.
3. We are at least eighteen (18) years of age and mentally competent to consent to this contract.
4. We are not related by blood to a degree of closeness, which would prohibit legal marriage in the state in which we legally reside.
5. By signing this Affidavit we acknowledge that we reside together in the same residence, have done so continuously for the past 4-consecutive months and intend to do so indefinitely.
6. We are jointly responsible for each other's common welfare and financial obligation, and by signing this Affidavit understand that MIT may reasonably request documents that reflect our joint financial responsibilities.

### III. Change in Spousal Equivalent Partnership

1. We agree to notify the MIT Student Health Plan or MIT Affiliate Health Plan office if there is any change in our status as domestic partners as attested in this Affidavit which would make us no longer eligible for this coverage (for example, a change in joint-residence status or if we are no longer each other's sole domestic partner). We shall notify the MIT Student Health Plan or MIT Affiliate Health Plan office in writing within 31 days of such change. In such notice, we will provide (i) the date on which such change occurred and (ii) confirmation that the student or affiliate and the former spousal equivalent partner have both received copies of such notice.

2. After such termination, I

\_\_\_\_\_  
Student or Affiliate (print)

understand that a subsequent Affidavit of Domestic Partnership cannot be filed until twelve (12) months after notification in writing of the termination has been filed with the MIT Student Health Plan or MIT Affiliate Health Plan office. All benefits of the former spousal equivalent partner will stop on the last day of the month that he or she ceases to be my spousal equivalent partner.

### IV. Acknowledgments

1. We understand that any companies or persons including but not limited to MIT who suffers loss due to any false statement contained in this signed Affidavit may bring a civil action against either or both of the parties who have signed this Affidavit to recover their losses, including reasonable attorney's fees.
2. We understand that any false statement contained in this Affidavit, including failure to provide updated information as required herein, may be grounds for termination of spousal equivalent coverage.
3. We have provided the information in this Affidavit for use by MIT Student Health Plan or MIT Affiliate Health Plan office for the sole purpose of determining our eligibility for spousal equivalent coverage and that the information will be held strictly confidential.
4. We affirm, under the penalty of perjury, that the assertions in this signed Affidavit are true to the best of our knowledge.
5. We understand that we may be upon request, required to submit such further documentation as MIT may from time to time request (examples may be, but not limited to, proof of common residence, driver's license, and joint bank statements) MIT may audit affidavits such as this from time to time.
6. We understand that this Affidavit is a legal document. We are aware that some court may recognize non-marriage relationship as the equivalency of marriage for the purpose of establishing and dividing community property and finances.
7. We agree that MIT will not be liable for any financial, legal, tax or other consequences as a result of our execution of this Affidavit or the provision of any benefits to, or for, a spousal equivalent partner.
8. We agree that any benefits provided by MIT to a spousal equivalent partner will be subject to the terms of the applicable plan, as modified by MIT from time to time.

*(Continued...see reverse side)*



# MIT Health Plan

**V. MIT's Rights**

MIT reserves the rights to terminate, modify, or adjust this policy and any benefits provided to or for spousal equivalent partners at any time and in its sole discretion.

Sign form below, certifying that the above information is true and accurate.  
Return form to address noted below.

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Student or Affiliate Signature Date

\_\_\_\_\_

\_\_\_\_\_

MIT ID Number

Student or Affiliate Address

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Spousal Equivalent Signature

Date

\_\_\_\_\_

Spousal Equivalent Address



**Return this form, together with a completed enrollment form, to: MIT Student/Affiliate Health Plans Office, 77 Massachusetts Ave, E23-308, Cambridge, MA 02139**

MIT Internal Use Only: I acknowledge receipt of this affidavit.

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MIT Student/Affiliate Health Plans Office Representative Date