SmileSaver
DOMESTIC PARTNER COVERAGE GUIDELINES

Smile Saver extends coverage for Domestic Partners. Domestic Partners are described by meeting the following COVERAGE GUIDELINES outlined below.

ELIGIBILITY FOR DOMESTIC PARTNERS

Our minimum eligibility standards include all of the following:

- Each partner must be at least 18 years of age
- The partners cannot be related by blood to a degree that would prohibit marriage
- The partners cannot be legally married to anyone else, or in a domestic partnership with another individual, nor can they have had another domestic partner in the last twelve months.
- The partners share the same permanent address
- The partners share joint financial responsibility for basic living expenses including food, shelter, and medical expenses.

The partners are financially interdependent which must be demonstrated by at least four of the following:

1. ownership of a joint bank account
2. ownership of a joint credit account
3. evidence of a joint mortgage or lease
4. evidence of joint obligation on a loan
5. joint ownership of a residence
6. evidence of common household expenses such as utility and phone bills
7. execution of wills naming each other as executor and/or beneficiary
8. granting each other durable powers of attorney
9. granting each other health care powers of attorney
10. designation of each other as beneficiary under a retirement benefit account
11. evidence of joint financial responsibility

ELIGIBILITY FOR CHILDREN OF DOMESTIC PARTNERS

The subscriber may want to include the dependent children of a covered domestic partner. In the event that a covered Domestic Partner's children are to be included, they will be eligible under the same terms and conditions of the contract as are the children of an enrolled employee. The children must also reside with the enrolled subscriber and the domestic partner.

ENROLLMENT GUIDELINES

A qualified Domestic partner can be added by completing the "Affidavit of Domestic Partnership" within 31 days of a subscribers initial eligibility date.

A copy of the signed affidavit must accompany the subscribers enrollment form upon enrollment.

TERMINATION GUIDELINES

Upon termination of a Domestic Partnership, a Statement of Termination must be completed and filed with The Plan. An affidavit for a new Domestic Partnership cannot be filed for a period of at least 12 months.

SmileSaver
DOMESTIC PARTNER COVERAGE GUIDELINES

DECLARATION OF DOMESTIC PARTNERSHIP

SECTION ONE

I, ___________________________________ SUBMIT THIS DECLARATION TO ESTABLISH
(Name of Subscriber)

_________________________________ AS MY DOMESTIC PARTNER.
(Name of Domestic Partner)

I declare and acknowledge that I and my Domestic Partner named above meet the following criteria:

1. are each eighteen (18) years of age or older,

2. reside together, sharing the same permanent residence for at least (12) consecutive months, with the current intent to continue doing so indefinitely;

3. are each other's sole domestic partner, are not married to anyone nor have had another domestic partner within the prior 12 months;

4. are not related by blood closer than would otherwise prohibit legal marriage in the state of residence;

5. are financially interdependent evidenced by at least four of the following (i.e. joint bank accounts, joint credit cards, joint ownership of a residence, household expenses, granting power of attorney, designating each other as sole beneficiary/executor) of evidence of other joint financial responsibilities.

6. are jointly financially responsible for basic living expenses.

SECTION TWO

1. I understand that coverage for my domestic partner shall terminate *upon* any change in circumstance attested to in this declaration. I also agree to provide written notice to The Plan if there is any change of circumstances attested to in this Declaration within 30 days of the change by filing a "Statement of Termination of Domestic Partnership." After such termination, I understand that an application to add a new domestic partner cannot be filed earlier than 12 months from the filing of a "Statement of Termination of Domestic Partnership" with The Plan.

2. We understand willful falsification of information contained in this Declaration will result in termination of coverage for my domestic partner and his or her children , if any.

3. We understand that under applicable federal and state income tax law, coverage of the non-employee domestic partner could result in additional imputed taxable

income to the employee, with possible withholding for payroll taxes (including income and social security taxes) on such amounts.

4. We understand that we would be well advised to consult an attorney regarding the possibility that the filing of this Declaration may have certain legal consequences.

5. We also certify under penalty of the State of California that the foregoing is true and accurate to the best of our knowledge.

________________________________		________________________________	
Name of Subscriber (Print)		Witnessed By (Print)	
__________________________	________	__________________________	________
Signature of Subscriber	Date	Signature of Witness	Date
________________________________		________________________________	
Name of Domestic Partner (Print)		Witnessed By (Print)	
___________________________	_________	__________________________	________
Signature of Domestic Partner	Date	Signature of Witness	Date

Street Address:

City, State. Zip:

SmileSaver
DOMESTIC PARTNER COVERAGE GUIDELINES

STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

Coverage for a Domestic Partner and his or her children, if included, terminates upon change of one or more
circumstances or criteria to in the Declaration of Domestic Partnership. Coverage will also terminate when the subscriber dies.

Upon termination of a Domestic Partnership, this form must be completed and filed with The Plan within 30 days of the change. After termination, a Declaration to add a new domestic partner cannot be filed for a period of at least 12 months from the filing of this statement.

All Questions Must Be Completed:

1. Subscriber Name ________________________________ Social Security #

Plan holder Name _____________________________________ Subscriber #

3. Reason For Termination: ______Change in eligibility criteria

______Death of my Domestic Partner Date:

4. Provide complete information for the person to be terminated:

Name of Domestic Partner (Last, First, MI)

Social Security Number: _____________________ Sex: ___ M ___ F Birth Date:

I represent that all the statements and answers given above are true, complete and correct.

____

Signature of Subscriber Date