



COLORADO CHOICE HEALTH PLANS
AFFIDAVIT OF
COMMON LAW MARRIAGE/CIVIL
UNIONS/DOMESTIC PARTNERSHIPS

Upon signing this form, we the undersigned, attest to the following facts:

1. I, _____, currently desire to enroll in Colorado Choice Health Plans and _____ is my spouse/partner who desires to be covered as an eligible dependent.
2. We profess to be married/partners and we hold ourselves out to the community as being such.
3. That we are eighteen years of age or older, or if between the ages of sixteen and eighteen, have obtained appropriate parental or guardian consent.
4. There is no legal impediment to our union, including but not limited to a prior marriage/union of either party that has not been legally terminated by death or divorce.
5. We understand that our marriage/civil union/domestic partnership relationship can be terminated legally only through death or divorce.

We represent that the information contained herein is true and complete to the best of our knowledge, and that **we are willing to provide supporting documentation, including a court order or registered license recognizing this as a legal marriage/union.**

Subscriber's Name (Please print)

Subscriber's Signature

Subscriber's Social Security Number

Date

Spouse/Partner Name (Please print)

Spouse/Partner Signature

Spouse/Partner Social Security Number

Date

Sworn to before me this _____ day of _____, 20_____

Notary Public

My Commission Expires

Notary Public's Address

Notary Seal

City State Zip