



**AFFIDAVIT
CERTIFYING A COMMON-LAW SPOUSE**

PLEASE PRINT OR TYPE

SUBSCRIBER: *By signing this affidavit certifying a common-law spouse, you are stating, under penalty of perjury, that you and your common-law spouse are eligible for coverage because you meet the following conditions:*

- | | | | |
|--|--------------------------|--------------------------|---------------------------------|
| | Yes | No | Both parties
please initial: |
| ▪ Have you been living together continuously for the past two (2) years? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ▪ Are you eligible for legal marriage, without emancipation? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ▪ Have you ever been married? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ▪ Have you ever been divorced? (If yes, must provide divorce decree.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

SUBSCRIBER INFORMATION

Last Name, First Name, Middle Initial	Age	Date of birth	Sex
---------------------------------------	-----	---------------	-----

Social Security Number

Home Address

Home Phone	Work Phone	Employer
------------	------------	----------

SPOUSE INFORMATION

Last Name, First Name, Middle Initial	Age	Date of birth	Sex
---------------------------------------	-----	---------------	-----

Social Security Number

Home Address

Home Phone	Work Phone	Employer
------------	------------	----------

By signing below, you and your spouse certify that all of the information provided is true and correct. You understand that any misrepresentation may be grounds for denial of coverage, recovery of benefits already paid or other action(s) deemed necessary by StayWell as a result of the extension of health insurance coverage.

Subscriber's Signature	Date	Spouse's Signature	Date
------------------------	------	--------------------	------

Subscribed and sworn before me this _____ day of _____, 20__ .

Notary Public
My commission expires: _____
 SW_CommonLawAff_032006