Point32Health

DOMESTIC PARTNER STATEMENT OF CANCELLATION

I declare and acknowledge that my domestic partner and I ***no longer meet the eligibility requirements*** for benefits coverage as domestic partners under Point32Health Services, Inc., its affiliates and subsidiaries (hereinafter called "Point32Health") benefits program in accordance with the following criteria:

I. ELIGIBILITY for Domestic Partnership:

A. We are at least 18 years of age. (To be covered under your life insurance policy your partner cannot be more than 70 years of age.)

B. We are not married to anyone and we share a mutually exclusive and enduring relationship.

C. We are not blood relatives close enough to prohibit legal marriage.

D. We have shared a common residence for at least 6 consecutive months and intend to do so indefinitely.

E. We understand that proof, satisfactory to Point32Health, of 6 consecutive months of shared residence will be requested and verified at the time of enrollment.

F. We consider ourselves life partners and share joint responsibility for our common welfare.

G. We are financially interdependent and have agreed to assume financial responsibility for the welfare of each other.

H. We have not signed a domestic partner affidavit with any other person within the last 6 months.

I. We understand that parents, siblings and roommates are ineligible to be added as a domestic partner.

II. CHANGE IN STATUS:

We agree to notify "Point32Health" Human Resources Department within 30 days if there is any change in our status as domestic partners which would make us no longer eligible for benefits (for example: death of domestic partner, change in joint-residency). We will notify "Point32Health" within thirty (30) days of such a change by submitting a Statement of Cancellation. Coverage will end on the date which any of the eligibility are no longer satisfied, or the date coverage ends according to the terms of the plan or federal or Massachusetts law.

III. ACKNOWLEDGMENTS:

A. I understand that the plan document for each plan governs all questions of coverage.

B. I understand that COBRA will be made available to domestic partners and/or their dependents if a family status change (as defined in the policy) occurs.

IV. STATEMENT OF CONFIDENTIALITY:

A. Point32Health will keep information obtained in the Statement of Enrollment in the strictest confidence. Such information will not be used for any other purpose or released without consent.

B. I have provided the information in this Statement of Enrollment for use by "Point32Health" Human Resources Department for the sole purpose of determining our eligibility for domestic partner benefits and administering domestic partner benefits as necessary.

C. I affirm, under penalty of perjury, that the assertions in this Statement of Enrollment are true to the best of our knowledge.

D. I understand that any misrepresentation may result in the rescinding of coverage.

_____

Employee Signature

_____

Date