Protective Life Insurance Company
PO Box 96
Birmingham AL 35201-0096
Phone: 800-568-2001 | Fax: 303-262-5463
Email: ada@protective.com
Website: ada.protective.com

Please complete this form and return it to Protective Life by fax, email or mail.

Coverage for your Domestic Partner is available under the ADA Term Life, Level Term Life, Hospital Indemnity and Critical Illness Insurance Plans. Also under MedCASH if member is currently insured under this plan.

I _____ (print name of ADA Member) certify that I and

_____(print name of Domestic Partner) reside together at:

_____(address) as a

non-married cohabiting couple and we intend to cohabit indefinitely and share the common necessities of life.

CRITERIA

We hereby affirm that:

1. Neither is married, legally separated or a Domestic Partner to another.
2. The effective date of this Domestic Partnership is_____
3. We are at least eighteen (18) years of age and mentally competent to consent to this Affidavit.
4. We are not related by blood, closer than would bar marriage in the State in which we are cohabiting, and are mentally competent to consent to contract.
5. We are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for our common welfare.

CHANGE IN STATUS

1. We agree to notify Protective Life (the insurer) if there is any change of circumstances, including, for example, if we no longer cohabit or there is a change in tax dependent status attested to in this Affidavit, within thirty (30) days of said change, by filing a Statement of Termination of Domestic Partnership Termination. Such Statement shall affirm under penalty of perjury that the Partnership is terminated and that a copy of the Statement of Termination of Domestic Partnership has been mailed to the other partner, if applicable. Failure to notify the insurer within 30 days shall result in the ADA member being responsible for any benefits provided by the insurer on behalf of the Domestic Partner after the date of termination.

2. After such termination I, the ADA Member, understand that I cannot file another Affidavit of Domestic Partnership with the insurer and apply for insurance for a different Domestic Partner until at least six (6) months after the date the previous Statement of Termination of Domestic Partnership was filed with the insurer.

ACKNOWLEDGEMENT

1. We understand that any persons/company who suffer any loss because of a false statement contained in any Affidavit of Domestic Partnership may bring a civil action against us to recover their losses, including reasonable attorney's fees.
2. We provide the information in this Affidavit to be used by the insurer for the sole purpose of determining our eligibility for Domestic Partnership benefits. We understand that this information will remain confidential and will be subject to disclosure only upon our express written authorization or as legally required.

3. We affirm, under penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge. We understand that this form is not an application for insurance coverage and the purpose of this form is to establish the eligibility of the persons named herein for the coverage provided under the ADA Term Life, Level Term Life, Hospital Indemnity, Critical Illness or MedCASH Insurance Plan.

_____
Member's Date of Birth

_____
Signature of ADA Member

_____
Date

_____
ADA Membership Number

_____
Domestic Partner Date of Birth

_____
Signature of Domestic Partner

_____
Date