

**BCBSRI Insured Large Group Domestic Partner
Coverage Offering Election Form**

Company Name: _____

Parent Group #: _____

Effective Date: _____

Check Applicable Domestic Partner Types:

Same Sex Same Sex and Opposite Sex

If domestic partner coverage is only to be applicable to certain groups and/or subgroups under the above parent group #, please identify the specific groups and/or subgroups to which coverage will be extended:

Group #s: _____

Subgroups #s: _____

By signing this coverage election form, you, as an officer of the above named company, agree to offer domestic partner coverage to all eligible employees.

Company Officer Name (Print)

Company Officer Title

Company Officer Signature

Date