BCBSRI Self Funded Group Domestic Partner Coverage Offering Election Form

Company Name: _____

Parent Group #: _____

Effective Date: _____

Check Applicable Domestic Partner Types: _ Same Sex _ 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