AFFIDAVIT DECLARING COMMON-LAW MARRIAGE AND DEPENDENTS
Declaration/Termination Form

INSTRUCTIONS

1. Complete this form if you want to declare or terminate a common-law marriage and name a dependent.
2. The termination of a common-law marriage must be declared to University of Colorado Medicine within thirty-one (31) days of such termination and a divorce decree or a legal separation decree must be submitted.
3. Review, SIGN and Date the backside of this form.

EMPLOYEE INFORMATION

Name (Last) (First) (Middle Initial)

Date of Birth (mm/dd/yyyy) Date of Employment

ENROLLMENT TYPE

☐ Declaring Common-Law Marriage **Effective Date**_____

DECLARATION OF COMMON-LAW MARRIAGE

We, the undersigned, being of lawful age, attest to the following facts:

I, _____, an employee of the University of Colorado Medicine and
(Employee Name)

_____, hereby declare that:
(Common-Law Marriage Partner's Name)

1. We have lived together continuously as husband and wife from _____, 20____ to the present time in the State of _____. During this period, we have professed to be husband and wife and we have held ourselves out to the community as being married.
2. We hereby publicly acknowledge that we are married by common-law and that both of us consent to and agree to be husband and wife and assume all the legal responsibilities and duties of lawfully married persons.
3. There is no legal impediment to our marriage including, but not limited to, a prior marriage of either party that has not been legally terminated by death or divorce.
4. We each certify that _____ (dependent spouse) is the Employee's common-law spouse pursuant to the laws of the State of Colorado.
5. We have submitted the required documentation.
6. The following named children are dependent upon the Employee or Spouse for financial support and qualify as Dependents under the terms of the Plan, Contract or Booklet/Certificate issued under the terms of the Plan, and the Employee is entitled to claim a deduction on his/her Federal Income Tax Return for each of the following children:

Name: SS Number: Date of Birth:

_____

_____

_____

_____

7. We hereby agree to provide, if requested, to either University of Colorado Medicine or to the health plan(s) selected, proof acceptable to each that the herein spouse or child(ren) qualify as a Dependent under my coverage. This proof may include, but is not limited to, a copy of the Employee's Federal Income Tax Return, legal adoption or legal guardianship papers.
8. We understand this Affidavit is binding and we can only make changes to University of Colorado Medicine health plan(s) during the annual open enrollment or within 31 days of a divorce decree, legal separation decree or death.

Employee Signature	Employee Printed Name	Date
Common-Law Spouse's Signature	Common-Law Spouse's Printed Name	Date

STATE OF _____)
) ss
COUNTY OF_____)

Sworn and subscribed before me this _____day of _____, 20_____ by

_____ and _____.
Witness my hand and official seal.

My commission expires _____.

_____
Notary Public

How to Return Your Form

By Mail	**By Fax**	**In Person**
Make a copy for your records and send the original to: University of Colorado Medicine HUMAN RESOURCES P.O. Box 111719 Aurora, CO 80042-1719	303-493-7601 Keep a copy of the fax transmission report with your form for your records.	Bring your completed original form to HUMAN RESOURCES. Retain a copy for your records.