USF UNIVERSITY OF SOUTH FLORIDA SYSTEM

Division of Human Resources

Domestic Partnership Declaration

DECLARATION

We, ________________________________ (Employee) and ____________________________ (Domestic Partner), certify to the University of South Florida System that we are domestic partners in accordance with the following criteria, and have continually fulfilled such criteria during the preceding six months. We make this Declaration for the purpose of participating in the Domestic Partnership Health Insurance Stipend Program.

CRITERIA

We further declare that:

- We are emotionally committed to one another, share joint responsibilities for our common welfare, and are jointly responsible for each other's financial obligations as demonstrated by the presentation of three of the required proofs below.
- We each are at least 18 years of age and are mentally competent to consent to a contract.
- Neither of us is legally married to anyone else, and we are not related to each other.
- We have shared financial responsibilities for at least the past six months.
- Domestic Partner is not employed or is not eligible for health benefits though his or her employer.
- We will provide proof of Domestic Partner's health insurance coverage and premium payment as required.

REQUIRED DOCUMENTS

The employee's partner must, if employed, show proof his or her employer does not provide health insurance coverage, or the partner is not eligible for coverage by the available plan. In addition, at least THREE of the following are required documentation of the relationship:

1. Joint ownership of real property
2. Mutual designation as attorney in a durable power of attorney document
3. Joint ownership of personal property or assets, such as automobiles or stock
4. Designation of health care surrogate
5. Joint bank account
6. Driver's license or tax documents showing the same address
7. Legal documentation demonstrating joint adoption or legal guardianship of any dependants, whether children or adults
8. Joint consumer or bank loan
9. Joint credit cards
10. Joint lease
11. Designation of beneficiary for life insurance, retirement plan and/or last will and testament

CHANGE IN DOMESTIC PARTNERSHIP STATUS

I, ________________________________ (Employee), agree to immediately notify Human Resources when we no longer meet all the criteria listed above by filing a Termination of Domestic Partnership Stipend Eligibility form. I understand that as of the effective date of the form, my domestic partnership status will cease, and I will no longer be eligible for the domestic partnership health insurance stipend.

After such termination, I understand that a subsequent Domestic Partnership Declaration form cannot be filed until six months have elapsed since the effective date of the termination of the prior domestic partnership, unless registering the same partnership.

ACKNOWLEDGEMENTS

By signing this declaration, I acknowledge I have been informed that:

1. USF reserves the right to request proof my partnership meets the emotional commitment and joint residency and financial interdependency eligibility criteria, and I agree to provide supporting documents when requested to do so.
2. If Domestic Partner becomes eligible for insurance coverage through his or her employer, I must notify HR within 15 days of the effective date of coverage by completing a Termination of Domestic Partnership Stipend Eligibility form, and I will no longer be eligible to receive the stipend.
3. If there is any change in our status as domestic partners as certified in this Declaration, I must notify HR within 15 days by completing a Termination of Domestic Partnership Stipend Eligibility form, and I will no longer be eligible to receive the stipend.
4. Any stipend received by me after the effective date of termination of my eligibility must be repaid to USF, and the amount may be deducted from future pay.
5. At least six months must elapse from the effective date of the Termination of Domestic Partnership Eligibility form before benefits for another domestic partner may be approved.
6. If I am employed under a contract or grant my stipend is conditioned upon the continuation of funding of the contract or grant, the terms of the contract or grant and the rules of the funding agency.
7. Applicable taxes will be withheld from the amount of the stipend I receive.
8. The information provided in this Declaration is for use by HR for the sole purpose of determining and maintaining eligibility for the Domestic Partnership Health Insurance Stipend Program.
9. An employee who knowingly makes false statements about satisfying the eligibility criteria or fails to notify HR of a change in status may be subject to disciplinary action up to and including discharge.

Employee Information

______________________________________ ________________________________
Print Employee Name *Employee ID*

______________________________________ ________________________________
Employee's Signature *Date*

Domestic Partner Information

______________________________________ ________________________________
Print Domestic Partner Name *Name of Employer (if applicable)*

______________________________________ ________________________________
Domestic Partner's Signature *Date*

Sworn to me this ________ day of ________, 2________

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Notary Public Signature and Seal