

## Affidavit of Domestic Partnership

### I. DECLARATION

We, \_\_\_\_\_ (employee name) and \_\_\_\_\_ (partner name) declare that we are Domestic Partners in accordance with the following criteria, and that we have initially and/or continually fulfilled such criteria within the six (6) months prior to the submission of this affidavit.

### II. CRITERIA

We further declare that:

1. We are each other's sole Domestic Partner and intend to remain so indefinitely;
2. We reside together in the same principal residence;
3. 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 two of the following\*:
  - a. joint ownership of real property demonstrated by a lease, mortgage, or deed; or
  - b. common ownership of an automobile; or
  - c. joint bank accounts; or
  - d. a will, retirement plan, or life insurance policy designating the other as primary beneficiary; or
  - e. a rental agreement showing both parties; or
  - f. driver's licenses showing the same address for both parties; or
  - g. IRS tax returns showing the same address for both parties; or
  - h. durable property or healthcare power of attorney granted by either party to the other.
4. We are each at least 18 years old and mentally competent to consent to a contract;
5. We are not related by blood closer than would bar marriage in the State of Florida;
6. We are not legally married to each other or anyone else and are not involved in any other Domestic Partnership.

*\* For the two criteria selected from #3 above, proof reflecting dates no older than six month(s) must be attached to this affidavit. Copies are acceptable and all documents must have the same address. During the annual Open Enrollment period or after experiencing certain qualifying status changes (such as a loss of coverage), supportive documentation may be greater than six (6) months old.*

### III. DEPENDENT(S) INFORMATION (Include the Domestic Partner and any children's information here.)

We declare as eligible dependent(s):

Dependent's Name	Date of Birth	SSN
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Dependent's Name	Date of Birth	SSN
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Dependent's Name	Date of Birth	SSN
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Dependent's Name	Date of Birth	SSN
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### IV. CHANGE IN DOMESTIC PARTNERSHIP STATUS

I, \_\_\_\_\_ (employee) agree to notify the UFHR-Benefits within 60 days should we cease to meet the criteria listed in Section II above by filing an "Affidavit of Termination" form. I understand that upon signing such an Affidavit of Termination, the Domestic Partner will no longer be eligible for coverage under the University of Florida's Domestic Partnership program.

**Affidavit of Domestic Partnership (continued)**

**V. ACKNOWLEDGEMENT**

**This policy is not designed to treat unmarried relationships as marriage or the substantial equivalent thereof.**

By signing below:

We have provided this information in the Affidavit for use by UFHR-Benefits, the University of Florida ID Card Services Department and its agents, and assigns for the purpose of determining eligibility for University of Florida Domestic Partner insurance plans, UFSelect, UF ID Card services or any other benefits that may become available for partners.

We affirm, under penalty of perjury, that the information in the Affidavit is true and complete to the best of our knowledge. We acknowledge and agree to the terms stated herein and we understand that any misrepresentation may result in termination of coverage.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

**IMPORTANT NOTE:**

*You are urged to seek appropriate advice before signing this Affidavit. There may be other implications to signing this document. Under federal and certain state laws, employer premium contributions for domestic partners may be subject to income and FICA taxes. This could have a significant impact on your tax status and net pay. Employer contributions can exceed \$600/payroll. Please contact UFHR-Benefits for current rates. Please note that UFHR-Benefits cannot provide legal, financial, or tax advice including calculating taxes and net pay.*

Employee Information

Partner Information

\_\_\_\_\_  
*Print Employee's Name*

\_\_\_\_\_  
*Print Domestic Partner's Name*

\_\_\_\_\_  
*UFID*

\_\_\_\_\_  
*UFID (if applicable)*

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Domestic Partner's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Date*

**Notary for Employee's Signature:** State of Florida, County of \_\_\_\_\_, Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_, personally known \_\_\_\_\_ or produced \_\_\_\_\_ identification.

\_\_\_\_\_  
*Signature of Notary Public – State of Florida*

**Notary for Domestic Partner's Signature:** State of Florida, County of \_\_\_\_\_, Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_, Personally known \_\_\_\_\_ or produced \_\_\_\_\_ identification.

\_\_\_\_\_  
*Signature of Notary Public – State of Florida*

Internal Use Only:

\_\_\_\_\_  
*Benefits and Retirement Receipt*  
UF – DP AFF – 4-14

\_\_\_\_\_  
*Date*

## Affidavit of Termination of Domestic Partnership

### I. DECLARATION

I, \_\_\_\_\_, declare the following:  
*(Print Employee's Name)*

1. I no longer meet the criteria to maintain a Domestic Partnership with \_\_\_\_\_.  
*(Print name of Former Partner)*
2. I am filing this Affidavit of Termination in order to void the Affidavit of Domestic Partnership filed with the University of Florida with respect to the person named above.
3. I am mailing my former Domestic Partner a copy this Affidavit of Termination of Domestic Partnership, by registered mail to the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
*(Indicate address to which copy of affidavit will be mailed)*

A copy of this notice will be mailed on \_\_\_\_\_.  
*(Date Mailed)*

### II. ACKNOWLEDGEMENT

I have provided this information in the Affidavit for use by the UFHR-Benefits and its agents and assigns for the purpose of determining eligibility for and participation in the University of Florida Domestic Partner plan, UFSelect and any other benefits offered to partners by the Domestic Partner named herein.

I affirm, under pain and penalty of perjury, that the information in the Affidavit is true and complete to the best of our knowledge; I acknowledge and agree to the terms stated herein; and I understand that any misrepresentation may result in termination of coverage.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

#### Employee Information

\_\_\_\_\_  
*Print Employee's Name*

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*UFID*

\_\_\_\_\_  
*Date*

**Notary:** State of Florida, County of \_\_\_\_\_ Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_, personally known \_\_\_\_\_ or produced \_\_\_\_\_ identification.

\_\_\_\_\_  
*Signature of Notary Public – State of Florida*

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#### Internal Use Only:

\_\_\_\_\_  
*UFHR-Benefits Receipt*

\_\_\_\_\_  
*Date*