UF | Human Resources
UNIVERSITY of FLORIDA

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 have continuously fulfilled such criteria for at least six (6) consecutive 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, documentation presented must demonstrate that the partnership is at least 6 months old. Copies are acceptable and all documents must have the same address.*

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

I declare the following as eligible dependent(s):

Domestic Partner's Name	Date of Birth	SSN
Child's Name	Date of Birth	SSN
Child's Name	Date of Birth	SSN
Child's Name	Date of Birth	SSN

IV. CHANGE IN DOMESTIC PARTNERSHIP STATUS

I,_____(employee) agree to notify 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. ***Additionally, I agree to notify UFHR Benefits within 60 days of marriage.***

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, UF Select plans, 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_____, 2_____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_____, 2_____by_____. Personally known_____or produced_____identification.

_____
Signature of Notary Public – State of Florida

Internal Use Only:

_____	_____
UFHR Benefits Receipt	*Date*

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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 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 plans, and any other benefits offered to partners by the Domestic Partner named herein.

I affirm, under 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_____, 2_____by_____, personally known_____or produced _____ identification.

_____
Signature of Notary Public – State of Florida

Internal Use Only:

_____ _____
UFHR Benefits Receipt *Date*