Affidavit of Domestic Partnership

I. DECLARATION

We, ____________________________ and ____________________________ declare that we are Domestic Partners in accordance with the following criteria, and have continually fulfilled such criteria during the immediately preceding six months.

II. CRITERIA

We further declare that:

1. We are each other’s sole Domestic Partner and intend to remain so indefinitely;
2. We share a primary 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;
   b. common ownership of an automobile;
   c. joint bank accounts;
   d. a will, retirement plan, or life insurance policy designating the other as primary beneficiary;
   e. a rental agreement showing both parties;
   f. driver’s licenses showing the same address for both parties; or
   g. IRS tax returns showing the same address for both parties
   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 anyone else.

In certain circumstances a Member’s Domestic Partner and/or the Domestic Partner’s child(ren) may qualify as the Member’s “dependent” under the Internal Revenue Code. Health insurance provided for such dependent(s) is not subject to federal income tax and can be provided on a pre-tax basis.

III. CRITERIA

We further declare that the Domestic Partner and/or his/her child(ren) listed in Section IV will meet the following in order to be considered a “dependent” for Federal tax purposes:

1. Must live in the same household as the Member for the entire year (except for temporary absences such as vacations, hospitalization, etc.).
2. The Member provides more than half of the dependent’s support.
3. The dependent is a U.S. citizen or resident.
4. The dependent is not being claimed as a qualifying child on another person’s tax return.

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

I declare as eligible dependent(s):

Check the box if claiming dependent as a tax dependent per the criteria listed in Section III.

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V. CHANGE IN DOMESTIC PARTNERSHIP STATUS

I, __________________________ agree to notify the University of Florida, Benefits and Retirement office 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.

I, __________________________ agree to notify the University of Florida, Benefits and Retirement office within 10 days should any of my dependent(s) listed in Section IV above cease(s) to meet the criteria listed in Section III above, if applicable. I understand that upon such notification, I will no longer be eligible for nontaxable employer premium contributions with respect to such dependent(s). Failure to timely notify Human Resource Services of the change may result in retroactive paycheck adjustments and re-filing of tax returns.

Affidavit of Domestic Partnership (continued)

VI. 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 the University of Florida, Benefits and Retirement office, 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 pain and 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.

Member Information

Print Member’s Name __________________________

UFID __________________________

Member’s Signature __________________________

Name of Employer __________________________

Date __________________________

Notary for Member’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:

Benefits and Retirement Receipt __________________________

Date __________________________

UF – DP AFF – 11-12
Affidavit of Termination of Domestic Partnership

I. DECLARATION

I, ________________________________, declare the following:

(Print Member’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 by me 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)

Or

I, ________________________________, declare the following:

(Print Member’s Name)

My dependents no longer meet the criteria as a “dependent” under the Internal Revenue Code.

List the dependents who no longer meet the “dependent” criteria under the Internal Revenue Code.

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II. ACKNOWLEDGEMENT
I have provided this information in the Affidavit for use by the University of Florida, Benefits and Retirement office 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.

Member Information

Print Member’s Name ________________________________ Member Number ________________________________
UFID ________________________________ Member’s Signature ________________________________
Name of Employer ________________________________ 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

Internal Use Only:

Benefits and Retirement Receipt ________________________________ Date ________________________________