We, _____ (*Employee*) and _____ (*Domestic Partner*), certify to the University of South Florida that we are domestic partners in accordance with the definition below. We also certify that _____ (*Domestic Partner*) is not employed or is not eligible for health benefits through his/her employer.

DEFINITION

1) We have been united in civil union in accordance with the state law of previous domicile, or

2) We meet the following:
   - 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.

REQUIRED DOCUMENTS FOR ENROLLMENT

1) The employee's partner must, if employed, show proof that his or her employer does not provide health insurance coverage, or the partner is not eligible for coverage by the available plan.

2) Proof of the partner's insurance coverage (*i.e. invoice or bill from insurance company*) and proof of payment.

3) State civil union certificate, or proof of three of the following:
   - Domestic Partner card
   - Joint ownership of real property
   - Mutual designation as attorney in a durable power of attorney document
   - Joint ownership of personal property or assets, such as automobiles or stock
   - Mutual designation of health care surrogate
   - Joint bank account
   - Driver's license or tax documents showing the same address
   - Joint consumer or bank loan
   - Joint credit cards
   - Joint lease
   - Designation of beneficiary for life insurance, retirement plan and/or last will and testament
   - Legal documentation demonstrating joint adoption or legal guardianship of any dependents, whether children or adults

DECLARATION

I have read and understand the definition(s) for the domestic partner listed above. I hereby affirm and attest to domestic partner eligibility. If any domestic partner is determined to be ineligible or I fail to notify University of South Florida Central Human Resources of a loss of eligibility or any supporting documentation is not provided upon request, I understand that I may be liable to repay any stipends received.

Verification of premiums will be required on a quarterly basis.

University of South Florida
4202 E Fowler Avenue, | Tampa, FL 33620-4301
813-974-2970 | usf.edu/hr

ACKNOWLEDGEMENTS

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

1. I must notify Central Human Resources within 15 days of the effective date of change by completing a Termination of Domestic Partnership Stipend Eligibility form and understand that I will no longer be eligible to receive the stipend:
    - If my Domestic Partner becomes eligible for insurance coverage through his or her employer.
    - If there is any change in the status as domestic partners as certified in this Declaration.

2. Any stipend received by me after the effective date of termination of my eligibility must be repaid to University South Florida, and the amount may be deducted from future pay.

3. 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. If my eligibility under the contract or grant should change, I will notify the University of South Florida Central Human Resources and complete a Termination of Domestic Partnership Stipend Eligibility form.

4. The information provided in this Declaration is for use by Central Human Resources for the sole purpose of determining and maintaining eligibility for the Domestic Partnership Health Insurance Stipend Program.

Employee Information

_____ _____
Print Employee Name *Employee ID*

_____ _____
Employee's Signature *Date*

_____ _____
Employee's Phone Number *Employee's Email Address*

Domestic Partner Information

_____ _____
Print Domestic Partner Name *Name of Employer (if applicable)*

_____ _____
Domestic Partner's Signature *Date*

Please email this completed form and the supporting documents to benefits@usf.edu.

University of South Florida
4202 E Fowler Avenue, | Tampa, FL 33620-4301
813-974-2970 | usf.edu/hr