I, _____ (*Employee*) certify and declare that I am no longer eligible to receive the Domestic Partnership Health Insurance Stipend, as of _____ (*Effective Date*).

I understand that the Domestic Partnership Health Insurance Stipend will terminate as of the Effective Date on this Termination of Domestic Partnership Health Stipend Form due to the reason indicated below:

☐ My domestic partner, _____ (*Name*) has become eligible for his or her own insurance coverage through his or her employer.

☐ I no longer have an eligible domestic partner as a result of either termination of the partnership, death of my partner, or marriage to my partner as it is described in Florida Statues, _____ (*Domestic Partner Name*).

☐ Other: _____

_____.

I understand another Domestic Partnership Declaration cannot be filed until six months have elapsed from the Effective Date (*as indicated above*) unless registering the same domestic partnership.

I affirm, under penalty of perjury, that the above statements are true and correct.

_____ _____

Employee's Signature *Date*

Please email this completed form to benefits@usf.edu.