

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 Statutes, _____ (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.