



Declaration of Domestic Partner Relationship

Certification

I, _____ and _____ certify that we live in a committed relationship and are each other's Domestic Partner in accordance with the following criteria and are eligible for University benefits as Domestic Partners.

- We are each other's sole Domestic Partner and intend to remain so indefinitely.
- We have lived together for at least 12 months.
- We are not legally married to anyone.
- We are both age 18 or older and mentally competent to consent to contract.
- We are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which we legally reside.
- We are jointly responsible for each other's common welfare and share financial obligations which could be demonstrated upon request by providing proof of the existence of at least three of the following (please check):

_____ joint mortgage or lease or other appropriate written evidence of common residence such as joint utility bills;

_____ designation of Domestic Partner as primary beneficiary in either: my or my Domestic Partner's will, or life insurance, or retirement plan;

_____ durable property or health care power of attorney;

_____ joint ownership of motor vehicle;

_____ joint checking account or joint credit account.

Employee Signature: _____

Date: _____

Employee Printed Name: _____

Domestic Partner Signature: _____

Date: _____

Domestic Partner Printed Name: _____



Declaration of Domestic Partner Relationship

Change in Domestic Partnership

I agree to notify the University within 30 days if any eligibility requirements listed above and certified in this Declaration are no longer satisfied which would make the Domestic Partner no longer eligible for University sponsored benefits.

I understand if the Domestic Partner relationship terminates that a subsequent Declaration of Domestic Partnership can be filed after twelve months after a Statement of Termination of the previous partnership has been submitted to the University.

Acknowledgement

I understand that I have the opportunity to cover my Domestic Partner under University benefits plans under the same terms and with the same privileges and restrictions that apply to spouses and eligible dependent children.

I understand that benefits I elect for my Domestic Partner using this Declaration will remain in effect as long as I meet the eligibility requirements.

I understand that the University is required by the Internal Revenue Service to report as taxable income the premium value related to covering my Domestic Partner under the employee health or dental benefit plans.

Employee Signature: _____ Date: _____

Employee Printed Name: _____

Employee Information

Name: _____

Social Security Number: _____ Date of Birth: _____

Home Address: _____

Campus Phone Number: _____ Dept.: _____

Domestic Partner Information

Name: _____

Social Security Number: _____ Date of Birth: _____