



UNIVERSITY OF FLORIDA

AFFIDAVIT OF DOMESTIC PARTNERSHIP

I. DECLARATION

Student: _____
_____ Last Name, First, Middle Initial _____ UF ID Number _____
_____ Social Security Number _____

Domestic Partner: _____
_____ Last Name, First, Middle Initial _____ UF ID Number _____
_____ Social Security Number _____

We provide this information to be used by the University for the sole purpose of determining our eligibility for domestic partnership services. We understand that this information is confidential and will not be released by the University unless expressly authorized by the student, except as otherwise required by law or a court of competent jurisdiction, or by the health insurance carrier that provides coverage. We declare that:

- We have a committed relationship of indefinite duration;
- We are both unmarried, and are not a member of another domestic partnership;
- We are both at least 18 years of age and are mentally competent to consent to contract;
- We are not related by blood to the degree prohibited in a legal marriage in the state of legal residence;
- We share the same primary residence;
- We are jointly responsible for each other's common welfare and shared financial obligations.
- The student has not filed an Affidavit of Domestic Partnership for another domestic partner in the last 12 months.

II. DOCUMENTATION

We are domestic partners who reside together in the same primary residence and are financially interdependent. We submit original documents of three of the following items (one of the three items must be from List A as proof of joint residence, and two of the of the three items must be from List B as proof of financial interdependence). (Note: original documents will be copied only to the extent necessary to document receipt and returned to you.)

List A	List B
Joint mortgage or lease	Joint bank account
Joint renter's or homeowner's insurance policy	Joint credit or charge cards
	Joint ownership of an automobile
	A "Domestic Partnership Agreement/ Contract"
	A life insurance policy designating the domestic partner as the primary beneficiary
	A will designating the domestic partner as the primary beneficiary
	A durable power of attorney or health care power of attorney naming the domestic partner as the attorney-in-

III. CHANGE IN DOMESTIC PARTNERSHIP

The student agrees to notify the Medical Records Manager at the Student Health Care Center if there is any change in our status as domestic partners or the dependency status of children of the student's domestic partner as certified in this statement which would make us no longer eligible for benefits. We will notify the University within thirty (30) days of such change by filing a "Notice of Termination of Domestic Partnership" with the Medical Records Manager at the Student Health Care Center. The Notice of Termination shall affirm the date that the domestic partnership status terminated. The student agrees to provide a copy of the Notice of Termination to his or her domestic partner within seven (7) days of the date of this notice.

IV. ACKNOWLEDGEMENTS:

- We acknowledge that our domestic partnership has been entered into willingly and voluntarily, and has not been entered into for the sole purpose of obtaining access to available domestic partner services;
- We have read and understand the University's Domestic Partner Services Policy;
- We understand that this affidavit may create between us certain contractual rights and legal obligations and that courts have recognized some non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing community property.
- We acknowledge that the eligible student shall be responsible for all debts incurred by the domestic partner for the provision of health care services at the Student Health Care Center.
- We acknowledge that the eligible student shall be responsible for the Optional Health Fee and that this fee shall not be pro-rated should a change in domestic partnership status occur.
- We acknowledge that the student may not file another Affidavit of Domestic Partnership until 12 months after the date of the Notice of Termination of Domestic Partnership. We further acknowledge that the 12-month waiting period will be waived only if another Affidavit is filed for the same domestic partner within 30 days following the filing of the Notice of Termination.

- We acknowledge that domestic partners are subject to the same insurance requirements governing all other students who are covered by, or are applying for, benefit plan coverage, including open enrollment periods.
- We acknowledge that any person, employer, or company who suffers any loss due to any false statements contained in this affidavit may bring a civil action against either or both of us to recover their losses, including attorneys' fees; and that any false statement may result in disciplinary action to the student, including reimbursing the University for any cost involved in providing any available services;
- We declare, under penalty of perjury, that the statements and information provided herein are true and correct.

I am applying for the following benefits for my domestic partner:

Student Government Health Insurance Student Health Center Optional Health Fee

Student Government Health Insurance for Eligible Dependents of Domestic Partners
(please complete form)

Student's Signature

Date

Domestic Partner's Signature

Date

Student's/Domestic Partner's Home Address

STATE OF FLORIDA
COUNTY OF _____

Affirmed and subscribed before me this ____ day of _____, _____ by _____.

Signature of Notary Public – State of Florida

Date

Commission Stamp

Personally Known

Presented Identification Type of Identification Produced _____

