



BROWARD COMMUNITY COLLEGE
Group Health and Dental Plans
AFFIDAVIT OF DOMESTIC PARTNERSHIP

I, _____, certify that I and _____
Name of Employee (print) Domestic Partner (print)

reside together and intend to do so indefinitely at:

Address _____

City _____ State _____ Zip Code _____

We affirm that the effective date of this domestic partnership is _____
Date

We are each eighteen years of age or older and mentally competent.

We are not related by blood in a manner that would bar marriage under the laws of the State of Florida.

We have a close and committed personal relationship, and we are each other's sole domestic partner nor married to or partnered with any other spouse, spouse equivalent or domestic partner.

For at least one year we have shared the same regular and permanent residence in a committed relationship and intend to do so indefinitely.

We are financially interdependent. We understand that "financial interdependence" means that we have entered into a contractual commitment for the financial responsibility or have joint ownership of significant assets (such as home, car, bank accounts) and joint liability for debts (such as mortgages, rent, major credit cards). Financial interdependence can be shown through at least two of the following:

- A jointly signed, notarized affidavit.
- Any other proof that establishes financial interdependency under the circumstances of the employee's particular case.
- Common ownership of real property or a common leasehold interest in the property.
- Common ownership of a motor vehicle or other material asset whose value exceeds \$5,000.
- Joint bank account or a joint credit account.
- Partner is designated as a beneficiary of the employee's life insurance or retirement benefits.
- Assignment from the employee of a durable power of attorney.

We understand that we will not be eligible for benefits until and unless we provide Broward Community College with true and accurate supporting documentation of financial interdependence.

We understand that domestic partners are subject to the terms and conditions governing all other employees who are covered by or applying for health or dental plan coverage.

We agree to notify Broward Community College if there is any change of circumstances attested to in this Affidavit within thirty (30) days of change by filing a Statement of Termination of Domestic Partnership with the Human Resources Department. Such termination statement shall be on a form provided by the College and shall affirm under a penalty of perjury that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner.

After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a statement of termination of the previous partnership has been filed with the College.

Each of us understands and agrees that in the event any of the statements set forth herein are not true, the insurance or health care coverage for which this Affidavit is being submitted will be rescinded and each of us shall be jointly and severally liable for any expenses incurred by the employer insurer or health care entity.

We provide the information in this Affidavit to be used by the College for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or pursuant to a court order.

We understand that there may be tax consequences resulting from the domestic partnership benefits and we agree that we are solely responsible for these tax consequences.

We affirm, under penalty of perjury, that the assertions in the Affidavit are true to the best of our knowledge.

Print Name

Print Name

Signature

Signature

Sworn to before me this _____ day of _____, 2001.

NOTARY PUBLIC