USF UNIVERSITY OF SOUTH FLORIDA

Division of Human Resources

Termination Of Domestic Partnership Health Stipend

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 am 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, _______________________________ (Name).

______ Other: ____

____.

I understand another Domestic Partnership Declaration cannot be filed until twelve 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*