AFFIDAVIT OF DOMESTIC PARTNERSHIP

1) **Domestic Partnership:** It is defined as an employee and one other person of the same or opposite sex. Each of the undersigned attest that we satisfy the definition of Domestic Partners set forth in 1) a through g below, and that we agree to 2) and 3).

   a) We are a couple in a relationship of mutual support, caring, and commitment.
   b) We are each other's sole domestic partner.
   c) We share the same permanent residence.
   d) We are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which we reside.
   e) Each of us is at least 18 years of age.
   f) Each of us is mentally competent to consent to contract.
   g) Neither of us is legally married to anyone.

2) **Termination of Domestic Partnership:** We, the undersigned employee or partner, agree to inform Pinellas County HR/Employee Benefits if there is any change in our status as domestic partners as attested to in this statement. We will notify HR/Employee Benefits within thirty (30) days of such change by filing a statement of Termination of Domestic Partnership, which will make the domestic partner no longer eligible for Pinellas County group health and/or dental plan benefits. The statement of Termination shall affirm that the Domestic Partnership status is terminated as of its date of execution and that a copy of the statement of Termination has been provided to the other partner by the party authorizing such action. We understand that upon the termination of our domestic partnership, health and/or dental plan coverage of the domestic partner who is not an employee in the Pinellas County Unified Personnel System as well as any dependents of such domestic partner, shall cease.

3) **Other:** We understand that any false or misleading statements made in order to receive benefits for which we do not qualify may subject the partner employed by Pinellas County to disciplinary action, up to and including termination of employment, loss of benefits, an obligation to reimburse Pinellas County for any costs involved in providing benefits coverage, and possible criminal prosecution or civil action.

   We have provided the information in this statement for the sole purpose of determining our eligibility for Pinellas County-controlled domestic partnership benefits. We understand that this information will be held confidential insofar as the law allows.

   We understand that only the employee portion of the health and/or dental plan premium can be a pre-tax payroll deduction. The portion pertaining to the partner and children of the partner is post-tax.

   We acknowledge Pinellas County's advice that we consult with a legal advisor before signing this document.

Date:_____ By:_____ _____
(Signature of Employee) Print Name

_____

_____ _____
Phone Number of Employee

_____
Address of Employee and Domestic Partner

SUBSCRIBED and SWORN TO BEFORE ME
this _____ **day of** _____

_____
Notary Public

Date:_____ By:_____ _____
(Signature of Domestic Partner) Print Name

_____
Print names of children of Domestic Partner to be covered under health insurance

SUBSCRIBED and SWORN TO BEFORE ME
this _____ **day of** _____

_____
Notary Public