



## Declaration of Domestic Partnership

We swear or affirm under penalty of perjury that:

1. We hereby verify that we have mutually agreed to be in a committed, serious, long-term relationship indefinitely with each other.
2. We are both at least eighteen (18) years old and are legally competent to consent to a domestic partnership.
3. We are not married; or a domestic partner, to any person other than the person with whom we are executing this Declaration of Domestic Partnership;
4. We are not related to the other by blood;
5. We have consented to the domestic partnership relationship without force, duress or fraud;
6. We are jointly responsible for each other's basic food, shelter, common necessities of life and welfare;
7. We share our primary residence with each other;
8. We consider ourselves to be a member of the immediate family of each other;
9. We share and coordinate financial responsibilities as domestic partners;
10. We understand that this Declaration does not afford our relationship any new or different legal status other than for the purposes herein as pertains to City of Sarasota employee benefits;
11. We understand that this Declaration is not intended to create any new or different rights or responsibilities.
12. We agree to notify the Human Resources Department, City of Sarasota within 30 days of any change in the status of our domestic partnership such that we no longer meet the criteria herein; and
13. We understand that if the domestic partner is not a legal tax dependent as described by the Internal Revenue Service under IRC Section 152, the above named City of Sarasota employee is responsible for payment of FICA and federal income tax on the value of any benefits extended to a domestic partner or the domestic partner's legally dependent child(ren).

The above representations are true and correct, and contain no material omissions of fact to the best of our knowledge and belief.

CITY OF SARASOTA EMPLOYEE			DOMESTIC PARTNER		
Printed Name (Last)	(First)	(Middle)	Printed Name (Last)	(First)	(Middle)
Signature of Partner as Stated Above			Signature of Partner as Stated Above		
Date of Birth _____			Date of Birth _____		
Mailing Address		City	State		Zip

**NOTARIZATION IS REQUIRED**

STATE OF FLORIDA  
COUNTY OF \_\_\_\_\_

Sworn to (or affirmed) and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ by \_\_\_\_\_  
and \_\_\_\_\_  who are personally known  or who have produced \_\_\_\_\_  
\_\_\_\_\_ as identification.

\_\_\_\_\_  
Notary Public



## Declaration of Domestic Partnership

### DOCUMENTATION

The documentation as indicated below is provided with this Declaration. Copies may be presented in lieu of originals. Documentation will be returned to you. Please check those items presented.

*To establish mutual residence, one (1) of the following must be presented.*

- Current mortgage, deed or lease showing both names
- Current driver's licenses showing the same address for both partners
- Current passports showing the same address for both partners
- Current tax returns showing the same address for both partners
- Current government issued photo identification showing the same address for both partners

*To establish shared and coordinated financial responsibility, one (1) of the following must be presented.*

- Current mortgage, deed or lease showing both names
- Current statement from joint bank account
- Current credit card statement with same account number for both names
- Vehicle title showing common ownership
- A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one domestic partner is the beneficiary of the other
- Wills designating the other as primary beneficiary

City Of Sarasota  
 Human Resources/Benefits  
 111 S Orange Ave, Room 204  
 Sarasota FL 34236

### 2009 SPOUSAL/DOMESTIC PARTNER SURCHARGE FORM

You have chosen to cover your Spouse/Domestic Partner under your Benefit coverage with the City. Please provide the following information and return this form to the City Benefit Office. If you have any questions, please call 951-3631.  
**\*IF YOUR SPOUSE/DOMESTIC PARTNER IS COVERED BY MEDICARE AS PRIMARY, THIS SURCHARGE WOULD NOT APPLY.**

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**Employee/Retiree Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ e mail: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ SS# \_\_\_\_\_  
 Date Of Birth: \_\_\_\_\_

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**Spouse/Domestic Partner Information:**

Name: \_\_\_\_\_ SS# \_\_\_\_\_  
 Date Of Birth: \_\_\_\_\_

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**Is your Spouse/Domestic Partner Employed:**

- Yes If YES, please supply the following employment information, sign and return to Human Resources.
- No If NO, please sign the form and return to Human Resources.

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**Spouse/Domestic Partner Place of Employment:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Health Coverage Available?  Yes  No

If Yes, does your spouse/domestic partner participate in the available coverage?  Yes  No

**Please Note:**  
 (If your Spouse/Domestic Partner has Health coverage available and declines coverage at their place of work, an additional \$50.00 per month will be added to your benefit costs)

**Coverage Provider:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**Signature:** \_\_\_\_\_

Please Note: By this signature, I attest the information I provide here is true and accurate.

**WEB TPA**  
employer services  
P. O. Box 1808  
Grapevine, TX 76099-1808  
FAX (469) 417-1733

**STUDENT DEPENDENT CERTIFICATION FORM**

GROUP NAME \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**EMPLOYEE'S INFORMATION**

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

**DEPENDENT INFORMATION**

Dependent's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Gender (check one)  Male  Female  
Relationship to Employee? \_\_\_\_\_  
Dependent is:  Single  Married  Divorced  Separated  
Does Dependent satisfy IRS Requirement for dependency?  Yes  No

**ADDITIONAL INFORMATION - This section must be completed or the form will be returned**

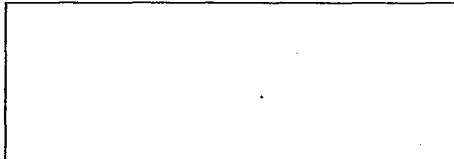
Name and Address of Institution where Dependent is enrolled: \_\_\_\_\_  
Is student considered a full-time student according to the requirements of the institution?  Yes  No  
Number of semester hours \_\_\_\_\_  
(graduate = 9; undergraduate = 12)  
If attending trade school - no. hrs. per week \_\_\_\_\_  
Please indicate which semester this form applies to:  
\_\_\_\_\_ Spring \_\_\_\_\_ (year) January 1 thru August 31  
\_\_\_\_\_ Fall \_\_\_\_\_ (year) September 1 thru January 31  
Is the dependent employed?  Yes  No  
If yes, please provide name of employer. \_\_\_\_\_  
Is dependent covered under any other Medical Plans?  Yes  No If, yes please provide the following:  
Insured Name \_\_\_\_\_  
Name and Address of Insurance Company \_\_\_\_\_

**I CERTIFY THAT THE INFORMATION IS TRUE AND COMPLETE. ALSO, I UNDERSTAND THAT ANY CHANGES TO THIS CHILD'S STUDENT STATUS MUST BE REPORTED TO MY EMPLOYER WITHIN 30 DAYS OF THE CHANGE. I AUTHORIZE THE SAID INSTITUTION TO RELEASE ANY INFORMATION REGARDING THE ENROLLMENT STATUS OF MY DEPENDENT SON/DAUGHTER.**

Patient/Authorized Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Registrar's Signature \_\_\_\_\_ Registrar's phone number \_\_\_\_\_

School Seal 

School seal must be visible when faxed or member will need to mail in the Hard copy in order for the form to be accepted as complete.