Termination of Domestic Partnership Health Insurance Stipend

I, ____________________________, certify and declare that ____________________________
(print employee’s name) (print domestic partner’s name)

Please check one:

☐ We are no longer domestic partners as of _______/_______/20___. (termination date)

The Domestic Partnership Health Insurance Stipend Declaration and Partnership Certification form
attested to and filed by me with the University of Central Florida shall be terminated as of the end of
the pay period in which the above referenced termination date falls. I understand that another
Domestic Partnership Health Insurance Stipend Declaration and Partnership Certification form cannot
be filed for the same partner until three (3) months have elapsed, or for a different partner until (6)
months have elapsed, from the partnership termination date referenced above.

☐ My partner is now eligible for health insurance through an employer, effective
   as of _______/_______/20___.

I understand that my domestic partnership health insurance stipend will terminate as of the end of
the pay period in which the above referenced effective date falls. Any stipend amounts received after
eligibility has terminated, or should have terminated, must be repaid to FAU and may be deducted
from future compensation.

I also affirm that the above statements are true and correct.

_________________________  ______________________
(employee’s signature) (today’s date)

Original forms should be forwarded to FAU Human Resources-Benefits
777 Glades Road, Administration, Room 114 • Boca Raton, FL 33431-0991

FOR HR USE ONLY
Benefits Authorization: ____________________________ Date Approved: ____________________________
Payroll Services Coordinator: ____________________________ Date Processed: ____________________________
Pay Period End Date: ____________________________