LEON COUNTY BOARD OF COUNTY COMMISSIONERS

AFFIDAVIT OF DOMESTIC PARTNERSHIP

I, ___________________________________, submit this Affidavit of Domestic Partnership to
(Name of Employee)

establish _____________________________________ as my Domestic Partner (as defined below)
(Name of Domestic Partner)
for the purpose of obtaining benefits that Leon County and the insurance carriers may extend to employees' domestic partners.

DECLARATION

We declare that we meet all of the criteria of the Leon County Domestic Partner Registration requirements (Leon County Ordinance 13-09):

- Are in a committed domestic relationship between two individuals.
- Are at least 18 years old and competent to contract and not currently married.
- Are not currently a partner in a domestic partnership relationship or a member of civil union with anyone else.
- Are not blood relatives, where one is a direct ascendant or direct descendant of the other (such as a son, daughter, parent, or grandparent), or a sister, brother, aunt, uncle, niece or nephew of the other domestic partner.
- Consent to the domestic partnership and to registering the domestic partnership without force, duress, or fraud.
- Agree to be jointly responsible in the support of the domestic partnership.
- Expressly declares his or her desire and intent to designate their domestic partner as their healthcare surrogate and agent to direct disposition of their body for funeral and burial; and
- Consider himself or herself as being in a committed domestic relationship with the other domestic partner and consider himself or herself to be a member of the immediate family of the other domestic partner.
- We have registered our Domestic Partnership at the Official Records Division of the Leon County Clerk of Courts.

DEPENDENT CHILDREN OF DOMESTIC PARTNERS

We understand the dependent children of _________________________________ are eligible for (Print Name of Domestic Partner) coverage providing, they meet all of the criteria for eligible dependents under the insurance plans and that the parent (domestic partner) must be covered under the plan to enroll the children.

Names of Children of Domestic Partner to be covered:

1. ____ 3. _____________________________________

2. ____ 4. _____________________________________

CHANGE IN DOMESTIC PARTNERSHIP

1. I agree to notify Leon County immediately of any change in the circumstances attested to in this Affidavit by completing an Affidavit of Termination of Domestic Partnership.
2. If my domestic partnership ends, I understand that another Affidavit of Domestic Partnership cannot be filed again until twelve (12) months from the date the Affidavit of Termination of Domestic Partnership was filed.

INCOME TAXES

I understand that if my domestic partner or the children of my domestic partner do not qualify as my legal tax dependents based on the Internal Revenue Code:

- The value of Leon County providing domestic partner coverage is included in gross income and subject to federal income taxes, social security (FICA) and Medicare taxes.

I understand I will be responsible for payment of all income taxes as a result of Leon County providing benefits to my Domestic Partner and his/her children. I am responsible for seeking legal and/or tax advice concerning this matter.

VERIFICATION

We will provide to Human Resources documents to verify Domestic Partner eligibility.
Required Documents:

- Certified Copy of Certificate of Registration with the Leon County Clerk of Courts recognizing the domestic partnership.

ACKNOWLEDGEMENT

We understand that providing false or misleading information in the Affidavit may result in any or all of the following action by Leon County: a requirement that we reimburse Leon County for all expenses, reimbursement to insurance company for any claims paid, termination of my employment and other legal action against me.
We understand that this declaration may have legal implications or implications to taxability of benefits provided. We should seek competent legal and tax advice concerning such matters.
We understand that domestic partner benefits may not be provided under all insurance plans and understand that we must meet the eligibility requirements of the particular benefit plan(s).
This document may be subject to section 119.07, Florida Statutes, Public Records Law.
I affirm that the assertions in this Affidavit are true to the best of my knowledge.

___________________________________	___________________________________
Employee's Signature	**Domestic Partner's Signature**
___________________________________	___________________________________
Date	**Date**

Notarization of both signatures is required:

State of Florida
County of ________________________

Sworn to and subscribed before me this ________ day of ________________, 20____,
By _______________________________ and____________________________ who are
_____Personally Known OR
_____Produced ID-Type of ID____

____
Signature of Notary Public-State of Florida

____
Print, Type or Stamp Commissioned
Name of Notary Public