Revised April 2012

University Health Service
University of Rochester

Application for Domestic Partnership Health Insurance Benefits

Student's Name: (Please Print)____

Student ID______________________________ Date of Birth: ________________

Address: ____

E-mail: ______________________________ Phone: __________________

Domestic Partner's Name: (Please Print) ____________________________________

Date of Birth: __________________________

I certify that we meet the following criteria as domestic partners for the purpose of being eligible for the University-sponsored health insurance for full-time University of Rochester students:

1. We have an exclusive mutual commitment, similar to that of marriage, but are not legally married.
2. We are each other's sole domestic partner and intend to remain so indefinitely.
3. Neither of us is legally married.
4. We are not related by blood.
5. We are both at least eighteen (18) years of age and are legally competent to contract.
6. We are currently residing together and have resided together in a common household for at least six (6) consecutive months and intend to reside together indefinitely.
7. It has been at least six (6) months since the University Health Service has received a Statement of Termination of a previous domestic partnership from either of us.
8. We share joint responsibility for our common welfare and financial obligations demonstrated by:
   a) the existence of a domestic partner agreement (a qualifying domestic partnership agreement is a legally binding agreement between two individuals creating personal and financial interdependence, i.e., joint and several liability for each other's debts and expenses, responsibility for mutual care, etc.)

   AND

   b) at least two other items showing joint responsibility, such as joint bank accounts, joint deed, mortgage agreement or lease, joint credit account or other liability, joint ownership of a motor vehicle, designation of domestic partner as primary beneficiary for life insurance or retirement contract(s), designation of domestic partner as primary beneficiary of will, durable property or health care power of attorney, co-parenting agreement, or an adoption agreement.

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By signing this application I, the undersigned student, understand that:

1. Domestic partners and their dependents are subject to the same plan guidelines, which govern all other participants in the University's benefits programs. The plan documents and the insurance contracts govern all questions of coverage.

2. The University Health Service reserves the right to request proof that the domestic partnership meets the eligibility criteria set forth above. I agree to provide the University with supporting documents (e.g., domestic partner agreement, the existence of joint bank accounts, joint liability for mortgages and the like) if requested to do so. The University Health Service in its sole discretion has the right to determine whether the criteria have been satisfied.

3. Although the University Health Service's present policy is to offer medical care continuation coverage to domestic partners through COBRA, it has no legal obligation to do so.

4. Unless I can claim my domestic partner and his/her dependent children as my dependents on my tax return, I understand that the Internal Revenue Service currently treats as imputed income to me the value of the University's contribution to medical and/or dental coverage for my domestic partner and his/her dependent children.

5. If there is any change in our status as domestic partners as certified in this application, I will notify the University Health Service within sixty (60) days of such a change. If this change results in a termination of the domestic partnership status, a Statement of Termination of Domestic Partnership must be completed and filed with the University Health Service Insurance Office. The domestic partnership status will be terminated as of the date the Termination Statement is signed.

6. I understand that the University Health Service may change its rules on domestic partners, on COBRA benefits, and any other aspect of the medical and dental plans at any time.

Please Check Applicable Boxes & Sign

I wish to enroll:

- ❑ My partner in the University-sponsored insurance for individual students.
- ❑ My partner and dependent children of my partner in the University-sponsored insurance for students.

The person(s) I wish to enroll qualify as my tax dependent(s) under the Internal Revenue Code.
Check one: ❑ YES ❑ NO

I affirm the statements made above are true and complete to the best of my knowledge and understand that false statements and/or the failure to notify the University Health Service of any changes in status can result in disciplinary action.

____
Signature of Student

____
Please Print Name

____
Date

Send to: UHS Insurance Advisor by mail to UHS, Box 270617, Rochester, NY 14627, by fax to (585) 756-0263, or by hand delivery to Room 204, UHS Building on the University of Rochester River Campus.