STATEMENT OF DOMESTIC PARTNERSHIP

DECLARATION

We, ___________________________ and ___________________________
(print faculty/staff members name) (print partner's name)
certify that we are domestic partners in accordance with the following criteria and eligible for medical and dental insurance coverage through the Harvard University benefit programs:

CRITERIA

1. We are each other's sole domestic partner and intend to remain so indefinitely. We are in a relationship of mutual support, caring and commitment. We share joint responsibility for our common welfare, and are financially interdependent;

2. Neither one of us is legally married and we are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which we legally reside;

3. We are at least eighteen (18) years of age and mentally competent to consent to contract;

4. We have resided together for at least six (6) months and intend to reside together indefinitely;

5. In order to be eligible for the Harvard University benefit programs, I must register my partnership with a municipality offering formal registration* and provide a copy of the registration certificate along with this Statement. (*The City of Cambridge and the City of Boston offer Domestic Partner Registries. Please check with your local municipality.)

6. It has been at least one (1) year since either of us has filed a statement of termination of a previous Statement of Domestic Partnership.

ACKNOWLEDGEMENTS

By signing this Statement, I declare and acknowledge my understanding that:

1. Domestic Partners are subject to the same plan guidelines which govern all other participants in the benefit programs. The plan documents and the insurance contracts govern all questions of coverage.

2. Harvard University reserves the right to request proof that my partnership meets the joint residency and financial interdependence eligibility criteria and I agree to provide Harvard University with supporting documents if requested to do so.

3. Harvard University has no legal obligation to offer COBRA continuation rights to domestic partners and their dependents; however, Harvard University has decided to offer continuation rights through COBRA at this time.

4. The Internal Revenue Service currently treats as imputed income to me the value of the medical and/or dental coverage provided to my domestic partner and his/her children, if any, minus any contribution paid by me for this coverage, except to the extent that any such individual represents a qualifying dependent of mine, defined as a “qualifying relative” or “qualifying child” under Internal Revenue Code Section 152.

Over –
5. By registering my domestic partnership with Harvard University, my domestic partner and his or her child may be considered my “spouse” and “child” for purposes of the Family and Medical Leave Act of 1993.

6. If there is any change in our status as domestic partners as certified in this Statement, we will notify Harvard University within thirty (30) days of such change. If this change results in a termination of the domestic partnership status, a Statement of Termination of Domestic Partnership must be completed. The domestic partnership status will be terminated as of the date the Termination Statement is signed.

7. After I have submitted a Termination Statement, at least twelve (12) months must elapse (from the date the Termination Statement is signed) before I may enroll another partner.

8. The information provided in this Statement is for use by the Benefits Office for the sole purpose of determining our eligibility for domestic partnership benefits.

9. Anyone who makes false statements about satisfying the eligibility criteria or fails to notify the University of a change in status will be subject to disciplinary action.

10. That Harvard University may change its rules on domestic partners, COBRA benefits, and any other aspect of the medical and dental plans at any time.

TO BE COMPLETED BY FACULTY/STAFF MEMBER

I affirm the statements made above are true and complete to the best of my knowledge. I understand that it is possible that this Statement could impose on me obligations to my domestic partner or to the creditors of my domestic partner.

____________________________________  _________________________
Signature of Faculty/Staff Member       Signature of Partner

____________________________________  _________________________
Print Name                              Print Name

____________________________________  _________________________
Harvard University ID# and Soc Sec #    Social Security #

____________________________________
Date of Birth

____________________________________
Date

For Benefits Use Only:

Certificate Number: ___________________  Initials: ___________________