STATEMENT OF DOMESTIC PARTNERSHIP

DECLARATION

We, _________________________________________ and ________________________________________,
(print faculty/staff members name) (print registered domestic partner's name)
certify that we are domestic partners in accordance with the following criteria and eligible for medical,
dental, and/or vision 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 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 intend to reside together indefinitely;

5. We have registered our domestic partnership with a municipality offering formal registration* and
   will 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.

*The City of Cambridge and the City of Boston offer domestic partner registration whether or not you are a
resident of the city. Please check with your local municipality first to see if they also offer this service.

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 currently offers continuation rights through
   COBRA-like coverage.

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 their child(ren), 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 their child(ren) 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 with the municipality where said partnership was registered. 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 can enroll another domestic 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. Harvard University may change its rules on domestic partners, COBRA-like benefits, and any other aspect of the medical, dental, and vision plans at any time.

TO BE COMPLETED BY FACULTY/STAFF MEMBER AND DOMESTIC PARTNER

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 Registered Domestic Partner

__________________________________________  __________________________________________
Print Name                                     Print Name

__________________________________________  __________________________________________
Harvard University ID# and Soc Sec #            Social Security #

__________________________________________  __________________________________________
Date of Birth                                   Date

For Benefits Use Only:

__________________________________________  __________________________________________
Certificate Number:                         Initials:
HARVARD UNIVERSITY
Harvard Human Resources

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Revised: October 2019