THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

DOMESTIC PARTNER ENROLLMENT

To Enroll a Domestic Partner:

Please complete, sign and have notarized the Domestic Partner Affidavit.

Provide the requested proof that you and your domestic partner live together and are financially interdependent.

Complete and sign the Domestic Partner Health Care Enrollment Statement.

Complete and sign the Dependent Verification Form by visiting the Benefits Department.

Present the enrollment information to:

Broward County Public Schools
Benefits Department
7770 W. Oakland Park Blvd.
Sunrise, FL 33351

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

DOMESTIC PARTNER – BENEFITS DEPARTMENT

Employees eligible for Domestic Partner Benefits from The School Board of Broward County, Florida (SBBC) can include their eligible domestic partners as dependents under their SBBC health, dental and/or vision insurance coverage. Any dependent children of an eligible domestic partner will also be eligible for coverage under these plans. However, domestic partners and their children will not be considered eligible dependents for purposes of Reimbursement Account participation and continuation of coverage (COBRA) in accordance with IRS rules.

NOTE: ***If you and your domestic partner are both full-time SBBC employees, this provision does not apply to you. You must each enroll as an employee for health care benefits.***

ELIGIBILTY

Domestic Partners

A domestic partner must be a person of at least eighteen years of age and not related to you by blood. To be eligible for coverage, the domestic partner must be your "sole spousal equivalent". You both must live together in an exclusive, committed relationship and assume joint responsibility for your basic living expenses. You must share the same residence and intend to continue to do so indefinitely. Neither you nor your domestic partner can be married, have another domestic partner, or have had another domestic partner at any time during the twelve (12) months preceding enrollment for health care benefits. You must complete a Domestic Partner Affidavit affirming these eligibility requirements.

Children of Domestic Partners

Your domestic partner's children can be enrolled as your dependents. If you enroll those children, they must be your domestic partner's natural children, stepchildren, legally adopted or foster children, who are unmarried and are under age 26. They must depend on you and your domestic partner for sole financial support and maintenance. Dependents serving in the military service are not eligible.

WHEN COVERAGE STARTS

You must enroll your domestic partner and your domestic partner's eligible children as your dependents within thirty-one (31) calendar days from the date you file your Domestic Partner Affidavit with the Benefits Department. Otherwise, you must submit satisfactory evidence of their insurability, in which case, their coverage will become eligible upon approval by the District of the evidence of insurability.

The actual effective date of your domestic partner and his/her children's coverage will be determined in accordance with SBBC's enrollment procedures.

COST OF COVERAGE

The contribution amount for adding your domestic partner and your domestic partner's children as dependents to your SBBC medical coverage is the same amount any employee would be required to pay to add a spouse and dependent children to his or her coverage. **Your contribution amount for dependent coverage will be deducted from your paycheck on a post-tax basis, for all plans in which the domestic partner and his/her dependents are enrolled.**

Taxable Income

Since the IRS does not recognize domestic partners and their children as dependents for federal income tax purpose, *SBBC will deduct the premium payments and the appropriate federal taxes from your paycheck.* These premium payments may be tax deductible. Consult your tax advisor.

Other Legal Consequences

Employees electing these benefits are advised to consult an attorney regarding the possibility that the filing of the Domestic Partner Affidavit may have other legal consequences. One consideration may be in the event of termination of the spousal equivalent relationship; a court may treat the relationship as the equivalent of marriage for the purpose of establishing and dividing community property, or for ordering payment of support.

WHEN COVERAGE ENDS

You must notify the Benefits Department within thirty-one (31) calendar days if either of these event occurs.

Coverage for your domestic partner or your domestic partner's children will end if:

- ✓ Your domestic partner dies; or
- ✓ The criteria for an eligible domestic partnership, as defined are no longer met.

You cannot file another Domestic Partner Affidavit for a new domestic partner for at least twelve (12) months from the time you file a Statement of Disenrollment of Domestic Partner.

You can file a Statement of Disenrollment of Domestic Partner at any time you wish to terminate coverage of your domestic partner and your domestic partners children.

Remember benefits for eligible domestic partners apply to health, dental, and vision insurance only.

Failure to notify the Benefits Department of a change in dependent coverage will result in premiums being deducted from your paycheck until the appropriate notification is provided.

ENROLLMENT INSTRUCTIONS

In order to enroll your domestic partner and/or your domestic partner's eligible children, you must complete and submit **Items 1 and 2** plus the additional requirements for group insurance benefits to the Benefits Department as stated below.

Item 1. Complete, sign and notarize the enclosed **Domestic Partner Affidavit**
Item 2. Provide proof that you and your domestic partner live together and are financially interdependent by submitting a copy of **at least one item from each** of the lists below.

LIST A

- ✓ Driver's Licenses showing the same address.
- ✓ Mortgage documents showing both names.
- ✓ Lease showing both names.
- ✓ Deed showing both names.
- ✓ Utility bills showing both names.

LIST B

- ✓ Statement(s) from a joint checking account.
- ✓ Credit card(s) with the same account number and both names.
- ✓ Designations of each person as authorized signatures for a safe deposit box or joint wills.

Additional Requirement for Group Insurance Benefits

To enroll you domestic partner and your domestic partner's eligible children for Group Insurance Benefits, you must complete and sign the enclosed **Domestic Partner Health Care Enrollment Statement** and submit it, along with your Benefits Enrollment Form. You are also required to complete and sign the Dependent Verification Form during your visit to submit the enrollment documents to the Benefits Department.

The non-employee domestic partner and his/her dependents do not have rights to continue coverage under Federal or State Law.

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
DOMESTIC PARTNER AFFIDAVIT

I, _____, affirm under the penalty of perjury as follows:
(Name of Employee)

1. _____ is my domestic partner. By that, I mean that:
(Name of Domestic Partner)

- ☐ We are both at least 18 years old and competent to enter into a contract.
- ☐ We have for the last twelve (12) months been, in an intimate, committed relationship which we intend to remain permanent.
- ☐ We live together.
- ☐ We are not related.
- ☐ Neither of us is married to other people.
- ☐ We are financially interdependent; each of us is responsible for the expenses and financial obligations of the other.

2. I understand that any false statements in this affidavit could lead to, among other things, termination of Group Insurance benefits, employment discipline, not excluding discharge, and other consequences.

Executed at _____ this _____ day of _____, 20 _____
City State Date Month Year

_____ _____
Employee's Personnel Number Employee's Signature

_____
Employee's Name (please print)

Notary Public
State of Florida, County of Broward
Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20 _____
Date Month Year

Signature of Notary: _____ _____
Seal or Stamp

Name of Notary: _____

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

DOMESTIC PARTNER BENEFITS ENROLLMENT STATEMENT

I wish to select the following benefits for my domestic partner and/or my domestic partner's eligible children (check all that apply).

Health Care Benefits:

- ☐ Health
- ☐ Dental
- ☐ Vision

I wish to enroll my domestic partner and his or her dependent children (listed on page 7), in above SBBC benefit plans as the Domestic Partner of _____

(Name of Employee)

I declare and acknowledge my understanding that:

- ✓ All group health care coverage is governed by the terms of the underlying plan(s).
- ✓ I have provided the documents establishing my Domestic Partner and we reside together and are financially interdependent.
- ✓ SBBC has no legal obligation to extend COBRA benefits to my domestic partner and his/her dependents.
- ✓ SBBC will deduct the premium payments and the appropriate federal taxes from my paycheck. I have an obligation to file a Statement of Disenrollment with the Benefits Department within thirty-one (31) calendar days of the death of my Domestic Partner.
- ✓ Regardless of whether the required Statement of Disenrollment has been filed, the termination date of coverage for my Domestic Partner and eligible dependents, will be the effective earliest of:

(a) The death of my Domestic Partner,

(b) The date on which I file a Statement of Disenrollment with the Benefits Department; **or**

(c) When the criteria for a Domestic Partnership relationship listed in the Domestic Partner Affidavit are no longer met by my Domestic Partner and me.

COST AND TAX IMPLICATIONS OF ADDING DOMESTIC PARTNER COVERAGE

You are responsible for paying income tax for the cost of the insurance coverage(s) in which your domestic partner and/or domestic partner dependent(s) are enrolled. The applicable tax will be withheld from your paycheck.

I have submitted the appropriate enrollment form(s) under the desired underlying plan(s). I request the coverage I have selected be provided for (check one):

- ☐ Myself and my Domestic Partner; **or**
- ☐ Myself, my Domestic Partner, and those children of my Domestic Partner or myself (eligibility requirements must be met).

Please provide the following information about your Domestic Partner and/or your Domestic Partner's eligible children.

Name (Last, First, MI)	Social Security Number	Date of Birth	Relationship
			Domestic Partner
			Child **Child**
			Child **Child**

Note: You must present <u>original</u> documentation of each eligible child's birth certificate, adoption agreement, or proof of dependency.

I agree to pay by payroll deduction any contributions required for this coverage.

Date _____

Employee's Signature _____

Employee's Personnel Number _____

Employee's Name _____

Day-Time Phone Number _____

Address _____

City _____ **State** _____ **Zip Code** _____