UNIVERSITY OF CALIFORNIA SAN FRANCISCO
RESIDENTS & CLINICAL FELLOWS HEALTH INSURANCE PLANS

DECLARATION OF DOMESTIC PARTNERSHIP
Send completed form to: Your Departmental Coordinator

We the undersigned certify that we are domestic partners in accordance with the following criteria and are eligible for benefits extended to domestic partners under the *UCSF Residents & Clinical Fellow Health Plans*.

Criteria of Domestic Partnership

- ☐ We are each other's only domestic partner and intend to remain so indefinitely. Neither one of us has been in a different domestic partner relationship within the past 6 months.
- ☐ We are at least eighteen years of age and neither of us is married.
- ☐ We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we reside.
- ☐ We reside together in the same residence and intend to do so indefinitely.
- ☐ We are jointly responsible for each other's common welfare and financial obligations.
- ☐ We agree to notify the Plan Sponsor, UCSF General Medical Education Office, or School immediately upon a change in our status such that we no longer satisfy any of the Criteria of Domestic Partnership.
- ☐ We understand that it is a fraudulent act to obtain health coverage by misrepresenting any facts stated herein.

Acknowledgments:

- ☐ We understand that UC/employer contributions for health coverage for eligible same-sex and opposite-sex domestic partner or partner's eligible child(ren) or grandchild(ren), may be imputed income and subject to the FICA (Social Security and Medicare) and/or federal and state income tax withholding. If the subscriber is an employee and enrollees are the subscriber's tax dependents and/or the partnership has been registered with the State of California, income will not be imputed for California state taxes. For non-employees, UC contributions towards subscriber's coverage may also may imputed - review the website for these details and/or forms: **https://hr.ucsf.edu/hr.php?A=157&AT=cm&org=c**

    - ☐ We are not registered with the State of California as Domestic Partners
    - ☐ We registered with the State of California as Domestic Partners. You must also complete the DECLARATION OF DOMESTIC PARTNERSHIP REGISTRATION FORM (page 2) to prompt a block to imputing of income.

- ☐ We understand that any person/employer/company who suffers any loss due to any false statement contained in this **Declaration** may action against either or both of us to recover their losses, including reasonable attorney fees.

- ☐ We have provided the information in this **Declaration** for use by the UCSF General Medical Education & Benefits Office or School for the sole purpose of determining our eligibility for domestic partner benefits.

- ☐ We affirm, under penalty of perjury, that the assertions in this **Declaration** are true to the best of our knowledge.

- ☐ I agree to notify the UC if the status of my domestic partner relationship changes - including termination of the relationship, or failure to meet any of the above criteria - no later than thirty (31) days from the date of such change.

_____	_____
Subscriber's Printed Name	Subscriber's SSN
_____	_____
Subscriber's Signature	Date
_____	_____
Partner's Printed Name	Partner's SSN
_____	_____
Partner's Signature	Date

RESIDENTS AND CLINICALFELLOWS

DECLARATION OF DOMESTIC PARTNER TAX DEPENDENCY AND/OR DECLARATION OF CALIFORNIA REGISTRATION OF DOMESTIC PARTNERSHIP

Send completed form to: Your Departmental Coordinator

This form serves two purposes:
1. To certify that your domestic partner and/or your partner's child(ren) or grandchild(ren) enrolled in a UC-sponsored health plan is your tax dependent.
2. And/or to certify that you have registered your domestic partnership with the State of CA.

If you have questions about tax dependency requirements, please request a copy of Publication 17—"Your Federal Income Tax" from the IRS. This publication contains tax dependency information as well as tables to determine who is a tax qualified dependent. We also suggest you consult a tax advisor. ***If the above certification process does not apply to you, you do not need to complete this form.***

SUBSCRIBER'S PERSONAL INFORMATION		
SUBSCRIBER'S NAME (Last, First, Middle Initial)		
SOCIAL SECURITY NUMBER		
CAMPUS/ DEPARTMENT		
CAMPUS PHONE	HOME PHONE	EMAIL ADDRESS
MAILING ADDRESS		
DOMESTIC PARTNER'S PERSONAL INFORMATION		
NAME (Last, First, Middle Initial)	BIRTH DATE (BD) MO DY YR	SOCIAL SECURITY NUMBER
Domestic Partner's Child(ren) or Grandchild(ren)		
NAME (Last, First, Middle Initial)	BD/MO DY YR	SOCIAL SECURITY NUMBER
NAME (Lest, First, Middle Initial)	BD/MO DY YR	SOCIAL SECURITY NUMBER
NAME (Last, First, Middle Initial)	BD/MO DY YR	SOCIAL SECURITY NUMBER
NAME (Last. First, Middle Initial)	BD/MO DY YR	SOCIAL SECURITY NUMBER

DECLARATION OF DOMESTIC PARTNER TAX DEPENDENCY – complete only if applicable

I understand that as part of UC's audit process I will be required to submit evidence of the tax dependency upon request. I understand that falsely certifying such dependency could result in disciplinary action from UC, as well as potential charges of tax fraud. I further agree to notify UC immediately of any change in this tax status.

I certify that the individual(s) named above, who are enrolled in University-sponsored health plans, are my tax dependents and declare under penalty of perjury that the statements above are true and complete to the best of my knowledge.

_____ _____
Subscriber's Signature Date

_____ _____
Partner's Signature Date

DECLARATION OF DOMESTIC PARTNERSHIP REGISTRATION – complete only if applicable

I understand that as part of UC's audit process I will be required to submit evidence of the tax dependency upon request. I understand that falsely certifying such dependency could result in disciplinary action from UC, as well as potential charges of tax fraud. I further agree to notify UC immediately of any change in domestic partnership status.

I certify I and my domestic partner, named above, have officially registered our domestic partnership with the State of California on the date (month/day/yr)_____, and declare under penalty of perjury that the statements above are true and complete to the best of my knowledge.

_____ _____
Subscriber's Signature Date

_____ _____
Partner's Signature Date

PRIVACY

NOTIFICATIONS STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting information on this form, including your Social Security number, is to verify your identity, and/or for benefits administration, and/or for federal and state income tax reporting. University policy and state and federal statutes authorize the maintenance of this information.

Furnishing all information requested on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be transmitted to the federal and state governments when required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from your Graduate Medical Education Office or School.

The official responsible for maintaining the information contained on this form is the Graduate Medical Education Office or School in coordination with the UCSF Central Insurance Desk, 3333 California Street, San Francisco, CA 94143-0918.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. The University's record keeping system was established prior to January 1, 1975 under the authority of The Regents of the University of California under Article 1X, Section 9 of the California Constitution. The principal uses of your Social Security number shall be for state tax and federal income tax (under Internal Revenue Code sections 6011.6051 and 6059) reporting, and/or for benefits administration, and/or to verify your identity