Pinellas County Human Resources
Helping U Succeed

2025 Affidavit of Domestic Partnership & Certification for Dependent Tax Status

1. Domestic Partnership

It is defined as an employee and one other person of the same or opposite sex. Each of the undersigned attest that we satisfy the definition of domestic partners below:

a) We are a couple in a relationship of mutual support, caring, and commitment.
b) We are each other's sole domestic partner.
c) We share the same permanent residence.
d) We are jointly responsible for each other's financial welfare and living expenses.
e) We are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which we reside.
f) Each of us is at least 18 years of age.
g) Each of us is mentally competent to consent to contract.
h) Neither of us is legally married to anyone.

2. Termination of Domestic Partnership

I, the undersigned employee, agree to inform Pinellas County Human Resources Employee Benefits if there is any change in our status as domestic partners as attested to in this statement. I will notify Employee Benefits within thirty one (31) days of such change by filing a Termination Statement of Domestic Partnership.

We understand that the termination of our domestic partnership will terminate health and/or dental plan coverage of the domestic partner as well as any dependents of such domestic partner.

3. Documentation of Joint Responsibility

We, the undersigned employee and partner confirm joint responsibility as attested by at least **two (2)** of the following items selected (provide the documents to Human Resources):

- ☐ Joint mortgage, joint property tax identification, or joint tenancy on a residential lease
- ☐ Joint bank account (checking or savings)
- ☐ Joint liabilities (credit cards, car loans, utilities),
- ☐ Joint ownership of significant property (vehicle, real estate, boat, etc.)
- ☐ Durable property or health care powers of attorney
- ☐ Naming each other as primary beneficiary in wills, life insurance policies, or retirement annuities
- ☐ Written agreements or contracts regarding the relationship showing mutual support obligation

4. Other

We understand that any false or misleading statements made in order to receive benefits for which we do not qualify may subject the individual employed by Pinellas County to disciplinary action, up to and including termination of employment, loss of benefits, an obligation to reimburse Pinellas County for any costs involved in providing benefits coverage, and possible legal action.

We have provided the information in this statement for the sole purpose of determining our eligibility for Pinellas County-sponsored domestic partnership benefits. We understand that this information will be held confidential insofar as the law allows.

We understand that this Affidavit of Domestic Partnership will cease to be valid on the earlier of the last day of the year or the execution of a Termination Statement of Domestic Partnership, or another qualifying life event.

Except as provided below, we understand that only the employee portion of the health and/or dental plan premium can be a pre-tax payroll deduction. The portion pertaining to the partner and children of the partner is post-tax and the value of the benefit must be reported as imputed income on the employee's annual W-2.

I understand that Pinellas County requires submission of a completed Certification for Dependent Tax Status (see page 3) and will use this certification to decide whether to treat my domestic partner and, if applicable, my domestic partner's child(ren) as my tax dependent(s) for healthcare purposes and that if I fail to complete this certification or any recertification requested by Pinellas County, then Pinellas County will assume that the individual(s) do(es) not qualify as my federal tax dependent(s) for health coverage purposes.

Refer to the Domestic Partner FAQs for additional details and important information.

EMPLOYEE

_____ _____

Employee Name | Employee Signature **(Do not sign until you are in front of a notary public.)**

_____

Employee ID Number

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____day of_____ 20____ ,

by_____

_____

Signature of Notary Public

DOMESTIC PARTNER

_____ _____

Domestic Partner Name | Domestic Partner Signature **(Do not sign until you are in front of a notary public.)**

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____day of_____ 20____ ,

by_____

_____

Signature of Notary Public

Please note the certification on the following page must also be completed but does not need to be notarized.

2025 Certification for Dependent Tax Status

I have read the information in this document, and I understand the requirements in the Internal Revenue Code for qualifying a domestic partner and/or a domestic partner's child or children as my federal tax dependent(s) for health coverage purposes. I understand that due to the potential impact of any imputed income, I should seek advice from a competent tax professional before certifying as to the tax status of covered individuals. I may wish to refer to www.irs.gov for information. For example, IRS worksheet Publication 501 can be used for determining the support tests under Internal Revenue Code section 152.

The individual(s) listed below qualify as my federal tax dependent(s) for health coverage purposes for 2025:

Domestic partner's name: _____ Birth date _____ ❑ Yes ❑ No

List each child of a domestic partner to be certified as a tax dependent:

_____ Birth date _____ ❑ Yes ❑ No

_____ Birth date _____ ❑ Yes ❑ No

_____ Birth date _____ ❑ Yes ❑ No

_____ Birth date _____ ❑ Yes ❑ No

I agree to notify Pinellas County in writing within thirty one (31) days if there is a change in the status of any of the above individuals as my tax dependent(s) for health coverage purposes, including any change that may occur mid-year. I understand that any change in such status may result in the retroactive application of taxes to amounts previously paid for health coverage during the year.

I understand that on the basis of the statements in this Certification, Pinellas County will decide whether to treat the above person(s) as my tax dependent(s) for healthcare purposes and that if I fail to complete this Certification or any recertification requested by Pinellas County, then Pinellas County will assume that the individual(s) do(es) not qualify as my federal tax dependent(s) for health coverage purposes.

I agree to reimburse Pinellas County for any and all taxes, penalties, or other losses (including reasonable attorneys' fees) that Pinellas County may incur as a result of its reliance on this Certification if it is untrue or incorrect in any respect, or if I fail to provide the notice required above.

I hereby certify that the above statements are true and correct. Additionally, I acknowledge that knowingly making a false statement may subject me to disciplinary action, up to and including termination of employment, loss of benefits, an obligation to reimburse Pinellas County for any costs involved providing benefits coverage, and possible legal action.

_____ _____

Type or Print Name Employee ID Number

_____ _____

Signature Date

Submit this completed form and documents to Employee Benefits, Human Resources, Annex Building, 400 S. Ft. Harrison Ave., Clearwater, FL 33756, or fax to (727) 453-3573. Questions? Call Benefits at (727) 464-3367, option 1.