UNIVERSITY OF RICHMOND

Declaration of Changes to Coverage of Domestic Partner
and/or Domestic Partner Child(ren)

I, _____ , certify and declare that my Domestic Partnership has ended, that I wish to voluntary disenroll my Domestic Partner and/or my Domestic Partner's child(ren) from coverage under the University of Richmond Employee Welfare Benefits Plan ("Plan"), or that my Domestic Partner and/or my Domestic Partner's child(ren) have experienced a permitted election change event under the terms of the Plan. I understand that coverage for health and dental benefits under the Plan for this individual will terminate.

The Change in Coverage of Domestic Partner and/or Domestic Partner Child(ren) is due to (check one (1) of the following options):

1. Voluntary Disenrollment (Non-Tax Dependents – Not Status Changes)

   Due to the fact that my Domestic Partner and/or my Domestic Partner's child(ren) is not my Code Section 152 tax dependent for health coverage purposes, I am allowed to terminate coverage for my Domestic Partner and/or my Domestic Partner's child(ren) (who is not my adopted or foster children) at any time throughout the year.

   _____ I wish to voluntarily disenroll the following individuals, who are not my tax dependents for health coverage purposes as defined in Internal Revenue Code Section 152, or, with respect to a Domestic Partner's child, who are not my adopted or foster children, effective immediately, from coverage under the Plan:

   _____

   I understand that coverage for these individuals will end on the last day of the month in which this completed Declaration is filed with the Human Resources Department.

2. Permitted Election Change Event (Tax-Dependents – Status Changes)

   _____ I wish to disenroll the following individuals, who are my dependents for health coverage purposes as defined in Internal Revenue Code Section 152, or, with respect to a Domestic Partner's child, who are my adopted or foster children, from coverage under the Plan due to the occurrence of the following permitted election change event on the specified date:

   _____

   I understand that coverage for these individuals will end on the last day of the month in which this completed Declaration is filed with the Human Resources Department.

3. Termination of Domestic Partnership

_____ My Domestic Partnership with _____ ended on _____.

I understand that coverage for my Domestic Partner and Domestic Partner's child(ren) (whether or not they are dependents for health coverage purposes as defined in Internal Revenue Code Section 152) will end on the last day of the month in which my Domestic Partner and I no longer satisfy the requirements for a domestic partnership (*e.g.*, change in residence, no longer jointly responsible for each other's common welfare and living expenses) as set forth in the Same-Sex Domestic Partner Benefits Policy.

4. Death of Domestic Partner

_____My Domestic Partner died on _____.

I understand that, if I selected # 3 above as the reason for submission of this Declaration, I may not submit for coverage for a new Domestic Partner for at least six (6) months from the date of termination of this Domestic Partner's coverage. I further understand that the above-named individual(s) may not be re-enrolled for coverage under the Plan until the next annual open enrollment period or upon the occurrence of a permitted election change event that would apply to an employee's spouse under the terms of the Plan.

I understand that the effect of filing this Declaration is that the above-named individual(s) will no longer be covered under the Plan. I further understand that the Plan has no obligation to provide conversion of health coverage to the above-named individual(s), although effective as of January 1, 2013, the University will extend COBRA-like rights to domestic partners and children of domestic partners under the Plan's self-funded benefits. Moreover, I understand that if, for any reason, the University of Richmond incurs costs on behalf of the above-named individual(s) after the above-specified termination date, then we will be required to reimburse the University of Richmond for any such costs (including any attorneys' fees incurred in order to collect such amounts).

In the event that submission of this Declaration is not due to the death of my Domestic Partner, I acknowledge that the University of Richmond will mail a copy of this Declaration to the above-named individual(s), at the following address provided by me:

_____

_____

(Print address for mailing of copy)

NOTE: If no address is provided, a copy of this Declaration will be mailed to the address on file with the Human Resources Department.

I certify under penalty of perjury, under the laws of the State of _____ that the foregoing is true and correct.

_____ _____
Signature of Employee Date

_____
Print Employee Name

_____

_____
Address

_____
Phone Number