

# Application For Optional On-campus Health Benefits

Student Health Center · Information Management · 618/453-3311  
Mailcode 6740 · 374 East Grand Avenue · Carbondale, IL 62901

Fee-paying students may purchase On-campus Health Care Benefits for the summer session if enrolled during the prior spring semester. Complete sections A, C & D below. Fee-paying students may also purchase On-campus Health Care Benefits for their Spouse or Same Sex Domestic Partner (SSDP). Complete all sections below and include a copy of your marriage license or, for a Same Sex Domestic Partner, a civil union certificate or completed Statement of Domestic Partnership (see back). Sign and return this form with check or payment info to address above. Deadline to purchase is Friday prior to the first day of class.

## A. Student Information

Name (last, first, middle)		Birth Date	Student ID #
Address		City / State	Zip Code
Home Phone	Work Phone	E-mail	

## B. Spouse / Same Sex Domestic Partner Information (complete only if purchasing coverage for your spouse/SSDP)

Name (last, first, middle)		Birth Date	Social Security #
Address		City / State	Zip Code
Home Phone	Work Phone	E-mail	

## C. Fees (check all that apply)

Term	Student	Spouse / SSDP
Fall 2009	N/A	<input type="checkbox"/> \$263.75
Spring 2010	N/A	<input type="checkbox"/> \$263.75
Summer 2010	<input type="checkbox"/> \$158.25	<input type="checkbox"/> \$158.25

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

Signature of Spouse / Same Sex Domestic Partner \_\_\_\_\_ Date \_\_\_\_\_

## D. Payment \*Required Field

<input type="checkbox"/> Cash <input type="checkbox"/> Check	
Make check payable to SIUC Student Health Center.	
<input type="checkbox"/> Master Card	<input type="checkbox"/> VISA
<input type="checkbox"/> Discover	<input type="checkbox"/> American Express
*Card #	*VIS #
*Expiration Date	
Card Holder Signature	

### Official Use Only

Processed By	Date
Effective Date	Termination Date
<input type="checkbox"/> Student Enrollment Verified <input type="checkbox"/> Marriage / Union Verified <input type="checkbox"/> Brochure Provide3	
08/05/09	

# Statement of Domestic Partnership

## For the Purchase of On-Campus Health Benefits

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### I. Declaration

I, \_\_\_\_\_ and \_\_\_\_\_ certify  
sponsoring student (print) domestic partner (print)

that we are domestic partners in accordance with the following criteria:

### II. Representations

1. We are each other's sole domestic partner and reside together in the same residence and intend to remain so indefinitely.
2. We are of the same sex and neither of us is married.
3. Each of us is at least eighteen (18) years old and mentally competent to consent to a contract.
4. We are not related by blood to a degree of closeness which would prohibit legal marriage (in the state in which we legally reside) if we were of opposite gender.
5. We are jointly responsible for each other's common welfare and share financial obligations. This may be demonstrated by the existence of three of the following items. We have circled below the types of documentation that we are providing.
  - a. Domestic Partnership Agreement.
  - b. Joint mortgage or lease.
  - c. Designation of domestic partner or beneficiary for life insurance.
  - d. Designation of domestic partner as beneficiary for retirement death benefit.
  - e. Designation of domestic partner as primary beneficiary in employee's will, or of employee in domestic partner's will.
  - f. Durable property and health care powers of attorney.
  - g. Joint ownership of motor vehicle.
  - h. Joint checking account.
  - i. Joint credit account.
6. We understand that any false or misleading statements made in order to receive benefits for which we do not qualify will result in termination of the On-Campus Benefits. If the services have already been received, the charges will be amended to reflect charges at full community rates.
7. We agree to notify the Student Health Center On-Campus Health Supervisor at 453-3311 if there is any change in our status as domestic partners as certified by this statement. This notification will be within thirty (30) days of such change by filing a written statement of termination of domestic partnership. The statement shall affirm that the domestic partnership status is terminated as of its date of execution and that a copy of the statement has been mailed to the other partner by the party authorizing such action. We agree that we may not declare a new domestic partner until twelve (12) months have passed.
8. We have provided the information in this statement for use by the SIUC Student Health Center for the sole purpose of determining eligibility for domestic partnership Student Health Center On-Campus Health Benefits and understand that this information will be held confidential to the extent allowed by law.
9. We understand and agree that the only benefits which may be made available to a domestic partner are those of the Student Health Center On-Campus Services and do not represent or imply insurance coverage for services received outside of the Student Health Center On-Campus Benefits.

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Signature of Sponsoring Student

Date

ID

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Signature of Domestic Partner

Date

ID