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Arizona Department of Administration
Benefit Services Division

Domestic Partner's Child Enrollment Forms & Instructions

The documents contained herein are to assist employees and retirees enrolling a Domestic Partner's Child

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Arizona Department of Administration

Domestic Partner's Child Certification Instructions

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Adding a Domestic Partner's Child

To add a domestic partner's child:

■ Complete and return the form(s) in this packet. You must complete a separate form for each child you are adding.

Step One (Tax Treatment):

■ Review the *Declaration of Tax Status* for the Domestic Partner's Child to determine whether your Domestic Partner's Child fulfills the requirements to be a tax dependent.

Your domestic partner's child does not need to qualify as a tax dependent to qualify for insurance coverage, however if your domestic partner's child does not qualify as a tax dependent, you may be taxed on any additional employer's contribution toward coverage.

■ If you are unsure whether your domestic partner's child meets the support requirement for dependent status, you may confirm eligibility by using the optional *Worksheet for Determining Support* form.

- ■ If completing the optional *Worksheet for Determining Support*, you will need to know your qualified domestic partner's ch
  - ▪ Gross monthly income, if any
  - ▪ Mortgage/ rental payment, if any
  - ▪ Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
- ■ Keep the worksheet for your personal records. You do not need to return the worksheet with the other forms.

■ Sign, date, and print your Employee ID Number (EIN) on the *Declaration of Tax Status* form.

Step Two:

■ Return the forms (excluding the Worksheet) to:
State of Arizona Department of Administration, Benefit Services Division
100 N. 15th Ave. Suite 103, Phoenix, AZ, 85007

Revised 8/6/08

Important:
Be sure to also submit a completed enrollment form.

Do **not** return this form; keep for your own records.

Arizona Department of Administration

Domestic Partner's Child Declaration of Tax Status

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You must complete a separate form for each child you are adding.

I, _____, declare

_____ as my Domestic Partner's Child.
Print Name of Domestic Partner's Child

I understand that my employer has a legitimate need to know the federal income tax status of my relationship. I understand that a Domestic Partner's Child is considered a tax dependent for purposes of employer provided health plans **only if** each of the following requirements are met:

1. My domestic partner's child is **NOT** my qualifying child as defined by IRC 152(c), or the qualifying child (dependent) of another taxpayer.
   Generally, to be a qualifying child under IRC 152(c) and also meet plan coverage eligibility, the child must:
   A.) Be your son, daughter, stepchild, foster child; **AND**
   B.) Be under age 19 at the end of the year, **OR**
   Be under age 24 at the end of the year and a full-time student, **OR**
   Be any age and permanently and totally disabled; **AND**
   C.) Have lived with you for more than half of the year.

AND

2. My domestic partner's child and I will live together (share our principal residence) for the full taxable year, except for temporary absences for reasons such as vacation, military service, or education.
   In other words, my domestic partner's child and I must live together from January 1st through December 31st.

AND

3. My domestic partner's child receives more than half of his or her support from me.
   Enclosed is a Worksheet for Determining Support, similar to the one the Internal Revenue Service (IRS) includes in its Publication 17, that you can use to determine whether you provide, or expect to provide, more than half of your older child's support.

AND

4. My domestic partner's child is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico, for some part of the year.

Check one of the following boxes. Since the above is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances.

Based on the criteria above, I declare that:
□ **Yes**, my domestic partner's child is reasonably expected to be my tax dependent for the 20___ calendar year.

□ **No**, my domestic partner's child is not expected to be my tax dependent for the year 20___ calendar year.
As a result, premium contributions for my domestic partner's child cannot be taken on a pre-tax basis and the value of the benefits my employer provides for my domestic partner's child may be added to my taxable income.

By signing this form:
I declare that the information I have provided is true, complete, and correct. If it is not, or if I do not update this information within the timelines stated in the benefit rules, I may be liable for any claims paid by my health plan(s) or premiums paid on my behalf and my registered domestic partner's child's behalf.
I understand that:
- This declaration of tax status may have legal implications under federal and/or state law.
- A civil action may be brought against me for any losses, including reasonable attorneys' fees, if I have made a false statement in this declaration.
- I must notify my benefits office if there is a change in the domestic partnership or domestic partner's child's tax status within 31 days of the change. A change in my family status may directly impact the calculation of my taxable income.

Subscriber's Signature	EIN	Date

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Worksheet for Determining Support

This worksheet is modeled after the Internal Revenue Service Publication 17 worksheet and requests historical information. However, it is necessary that you determine whether your domestic partner, older child, or domestic partner's child, will qualify as a dependent for the calendar year the dependent is enrolling (the "enrollment year"). Complete this worksheet using the income and expenses you anticipate during the enrollment year to determine if you provide more than one-half of the support for your domestic partner, older child, or domestic partner's child. A separate worksheet must be completed for each individual.

Important:
You can use this worksheet to determine whether an individual meets the support test to qualify as a tax dependent.

Individual's Income

1. Did the individiual you supported receive any income, such as wages, interest dividends, pensions, rents, social security, or welfare?
   - □ Yes (Answer questions 2, 3, 4, and 5.)
   - □ No (Skip to question 6.)
2. Total annual income received $ _____
3. Amount of income used for the individual's support $ _____
4. Amount of income used for purposes other than support $ _____
5. Amount of income either saved or not used for lines 3 or 4 $ _____

The total of lines 3, 4, and 5 should equal line 2.

Yearly household expenses where you and the individual live

6. Lodging *(Complete either a or b):*
   a. Rent Paid $ _____
   b. If not rented, show fair rental value of your home. If your domestic partner owned the home, include this amount on line 21. $ _____
7. Food $ _____
8. Utilities (heat, light, water, etc. not included in line 6a or 6b) $ _____
9. Repairs that were not included in line 6a or 6b $ _____
10. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance). $ _____
11. Add lines 6a or 6b through 10 $ _____
12. Total number of persons who lived in the household $ _____

Yearly expenses for the individual

13. Divide line 11 by line 12 to determine each person's part of household expenses
    $ _____ ÷ _____ = $ _____
    line 11 line 12
14. Clothing $ _____
15. Education $ _____
16. Medical and dental $ _____
17. Travel and recreation $ _____
18. Other (please specify) _____ $ _____
    _____ $ _____
    _____ $ _____
19. Total amount for the individual's yearly support (Add lines 13 through 18.) $ _____
20. Multiply line 19 by 50% (.50) $ _____
21. Amount the individual provided for his or her own support
    Line 3 $ _____
    Line 6b (include if the individual owned the home) $ _____
    Add lines 3 and 6b, if each are applicable $ _____
22. Amount that others added to the individual's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts from line 2. $ _____
23. Amount you provided for the individual's support:
    $_____ - $_____ - $_____ = $ _____
    line 19 line 21 line 22
24. Is line 23 more than line 20? If so, the individual qualifies as a tax dependent.

Check "Yes" on the *appropriate Declaration of Tax Status* form.

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STATE OF ARIZONA ACTIVE OPEN ENROLLMENT FORM 2009-2010

DATE RECEIVED	AGENCY	EFFECTIVE DATE

☐ **NEW EMPLOYEE** ☐ **QUALIFIED LIFE EVENT** ☐ **ADDRESS CHANGE** ☐ **TERMINATION**

EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	☐ MALE ☐ FEMALE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )

Are you enrolling a Domestic Partner?	**Yes or No**
Is your Domestic Partner: (circle one)	**Pre-Tax or Post-Tax**
Are you enrolling an Older Child(ren) that is neither a full-time student nor a disabled dependent? (circle one)	**Yes or No**
Is your Older Child(ren): (circle one)	**Pre-Tax or Post-Tax**

If you have already enrolled a qualified domestic partner or older child, you do not need to submit additional paperwork. If you are wanting to add a domestic parnter or older child during this open enrollment, please go to www.benefitoptions.az.gov to obtain the instructions and needed documentation.

MEDICAL PLANS (Employee Monthly Cost Listed)

☐ **I DECLINE MEDICAL COVERAGE**

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
EPO PLANS								
CIGNA EPO		☐ $39.00		☐ $97.00		☐ $79.00		☐ $178.00
AMERIBEN EPO		☐ $39.00		☐ $97.00		☐ $79.00		☐ $178.00
AETNA EPO		☐ $39.00		☐ $97.00		☐ $79.00		☐ $178.00
UNITEDHEALTHCARE EPO		☐ $39.00		☐ $97.00		☐ $79.00		☐ $178.00
PPO PLANS								
AMERIBEN PPO		☐ $154.00		☐ $328.00		☐ $309.00		☐ $443.00
AETNA PPO		☐ $154.00		☐ $328.00		☐ $309.00		☐ $443.00
UNITEDHEALTHCARE PPO		☐ $154.00		☐ $328.00		☐ $309.00		☐ $443.00
HSA OPTION								
AETNA HSA		☐ $25.00		☐ $80.00		☐ $59.00		☐ $150.00

DENTAL PLANS (Employee Monthly Cost Listed)

☐ **I DECLINE DENTAL COVERAGE**

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		☐ $5.00		☐ $9.00		☐ $14.00
DELTA DENTAL INDEMNITY/PPO		☐ $29.86		☐ $67.93		☐ $118.12

VISION PLAN (Employee Monthly Cost Listed)

☐ **I DECLINE VISION COVERAGE**

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		☐ $4.83		☐ $13.52		☐ $16.86

Effective January 1, 2009, all Active State employees will be required to provide social security numbers (SSNs) for their enrolled dependents.

The SSN is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. Please note that the Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for coordination of benefit purposes.

REVISED 08/12/09

2009 - 2010 OPEN ENROLLMENT FORM

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STATE OF ARIZONA ACTIVE OPEN ENROLLMENT FORM 2009-2010 CONTINUED

DEPENDENTS - List all eligible dependents to be enrolled or disenrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)	Date of Birth (MM/DD/YY)	Social Security Number	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT	DISABLED	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER	**REQUIRED**	**REQUIRED**			**Y OR N**	**Y OR N**	**A OR D**	
Employee			**S- Spouse** **C- Child** **D- Domestic Partner** **G- Guardian** **P- Placed for adoption** **T- Stepchild**					
Spouse or Domestic Partner			☐ S ☐ D	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***

SHORT-TERM DISABILITY

The Hartford Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay $0.70 for every $100 of earned income per month. Please see the Open Enrollment Guide for more information regarding Short-Term Disability coverage.

☐ **I DECLINE SHORT-TERM DISABILITY** ☐ **I ELECT SHORT-TERM DISABILITY**

SUPPLEMENTAL LIFE INSURANCE

Supplemental coverage is available in increments of $5,000. Your cost for Supplemental Life and AD&D insurance is based on your age as of October 1st (the first day of the plan year). Premiums for Supplemental Life coverage above $35,000 are paid on an after-tax basis. You may elect to increase your Supplemental Life coverage during Open Enrollment. The maximum amount you may elect during this Open Enrollment is 3 times your base salary or $300,000.00 whichever is lower.

☐ I DECLINE SUPPLEMENTAL LIFE INSURANCE

Total amount of employee coverage: $_____

DEPENDENT LIFE INSURANCE

☐ I DECLINE DEPENDENT LIFE INSURANCE

☐ **$2,000**	**$0.94/MONTH**	**Plan Code 02**	☐ **$12,000**	**$5.64/MONTH**	**Plan Code 12**
☐ **$4,000**	**$1.88/MONTH**	**Plan Code 04**	☐ **$15,000**	**$7.05/MONTH**	**Plan Code 15**
☐ **$6,000**	**$2.82/MONTH**	**Plan Code 06**	☐ **$50,000**	**$24.25/MONTH**	**Plan Code 50**

Beneficiary Last Name, First Name	Date of Birth
Beneficiary Street, City, State, Zip Code	Phone No.

EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify that under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/domestic partner and/or dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In addition, I have read and understand the declarations.

SIGNATURE:_____ **DATE:**_____

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 Or fax to: 602-542-4744

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