

Same-Sex Domestic Partner's Child Certification Instructions

Adding a Same-Sex Domestic Partner's Child

To add a same-sex 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.

Important Disclosure and Disclaimer:

The State of Arizona is not offering benefits to opposite-sex domestic partners. As a result of the U.S. District Court preliminary injunction (described in detail on page 5 in the "Changes" section of the 2011 Open Enrollment Guide), the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are ADVISED and CAUTIONED that the preliminary injunction possibly could be lifted after open enrollment or during the 2011 Plan Year. If that were to occur, the State of Arizona would no longer be compelled by the U.S. District Court injunction and the State of Arizona reserves the right to immediately discontinue offering benefits to qualified same-sex domestic partners during the 2011 Plan Year and thereafter.

This also would include dependent children of the non-employee qualified same-sex domestic partner unless those individual(s) were an actual dependent of the State employee as defined under the State's benefit plan. Qualified same-sex domestic partners and their dependents should not have an expectation that coverage will continue or an expectation that the benefits have vested for an entire plan year because preliminary injunction may be lifted in the future.

Step One (Tax Treatment):

- Review the *Declaration of Tax Status* for the Same-Sex Domestic Partner's Child to determine whether your Same-Sex Domestic Partner's Child fulfills the requirements to be a tax dependent.
Your same-sex domestic partner's child does not need to qualify as a tax dependent to qualify for insurance coverage, however if your same-sex 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 same-sex 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 same-sex domestic partner's child's
 - 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

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

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

Qualified Same-Sex Domestic Partner Affidavit

SECTION I:

I, _____ certify that _____ and I are domestic
Name of employee or retiree (print) Name of same-sex domestic partner (print)
partners and have been domestic partners since _____ and each of us:
Date of partnership mo/day/yr

- A. shares a permanent residence, and have resided with one another continuously for at least 12 consecutive months before filing an application for benefits and are expected to continue to reside with one another indefinitely as evidenced by this affidavit; **AND**
- B. has not signed a declaration or affidavit of domestic partnership with any other person and have not had another domestic partner within the 12 months prior to filing an application for benefits; **AND**
- C. does not have any other domestic partner or spouse of the same or opposite sex; **AND**
- D. is not currently married to anyone or legally separated from anyone else; **AND**
- E. is not a blood relative any closer than would prohibit marriage between us in Arizona; **AND**
- F. was mentally competent to consent to contract when the partnership began; **AND**
- G. is not acting under fraud or duress in accepting benefits; **AND**
- H. is at least 18 years of age; **AND**
- I. is financially interdependent in at least three of the following ways (circle applicable letter and supporting documents are required to be submitted):
 - a. having a joint mortgage, joint property tax identification, or joint tenancy on a residential lease;
 - b. holding one or more credit or bank accounts jointly, such as a checking account in both names;
 - c. assuming joint liabilities;
 - d. having joint ownership of significant property, such as real estate, a vehicle, or a boat;
 - e. naming the partner as beneficiary on the employee's life insurance, under the employee's will, or employee's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities;
 - f. each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney;
 - g. other proof of financial interdependence as approved by the Director

SECTION II:

- A. I understand that this affidavit shall be terminated upon the death of my same-sex domestic partner or by a change of circumstance attested to in the *Same-Sex Domestic Partnership Change Form* .
I agree to notify my agency or ADOA benefits representative if there is any change of circumstances attested to in the affidavit within (31) days of the change by filing a *Same-Sex Domestic Partnership Change Form* .
- B. After such termination, I understand that another Affidavit of Same-Sex Domestic Partnership cannot be filed until twelve (12) months after a *Statement of Same-Sex Domestic Partnership* has been filed with my agency or ADOA benefits representative.

_____	_____	_____
Employee / Retiree Signature	EIN	Date

State of _____, County of _____

Subscribed and sworn before me on this the _____ day of _____, 20____

Commission Expiration mo/day/yr

Notary Public

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 same-sex domestic partner, or same-sex 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 same-sex domestic partner, or same-sex 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 individual 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 same-sex 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

$$\frac{\$ \text{ line 11}}{\text{line 12}} = \$ \text{ _____}$$
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:

$$\$ \text{ line 19} - \$ \text{ line 21} - \$ \text{ line 22} = \$ \text{ _____}$$

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.

Benefit Options

Choice. Value. Health.

STATE OF ARIZONA ACTIVE ENROLLMENT FORM

DATE RECEIVED

AGENCY

EFFECTIVE DATE

NEW EMPLOYEE QUALIFIED LIFE EVENT ADDRESS CHANGE TERMINATION

EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN	EMPLOYEE SSN	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	
CITY, STATE, ZIP CODE	WORK PHONE NUMBER	HOME PHONE NUMBER	

Are you enrolling a same-sex Domestic Partner? (circle one) Yes or No

To qualify a same-sex Domestic Partner for the first time, you will need to complete and submit the DOMESTIC PARTNER AFFIDAVIT FORM (this form must be notarized). This form can be found on the Benefit Options website at www.benefitoptions.az.gov.

MEDICAL PLANS (Employee Per Pay Period Cost Listed)

I DECLINE MEDICAL COVERAGE OR

EPO PLANS

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
CIGNA EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102
AMERIBEN/BCBS of AZ EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102
AETNA EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102

PPO PLANS

AMERIBEN/BCBS of AZ PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31
AETNA PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31

HSA OPTION

AETNA HSA		<input type="checkbox"/> \$12		<input type="checkbox"/> \$47.08		<input type="checkbox"/> \$37.38		<input type="checkbox"/> \$89.08
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DENTAL PLANS(Employee Per Pay Period Cost Listed)

I DECLINE DENTAL COVERAGE OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$2.31		<input type="checkbox"/> \$4.15		<input type="checkbox"/> \$6.46
DELTA DENTAL INDEMNITY/PPO		<input type="checkbox"/> \$14.30		<input type="checkbox"/> \$32.71		<input type="checkbox"/> \$56.82

VISION PLAN (Employee Per Pay Period Cost Listed)

I DECLINE VISION COVERAGE OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		<input type="checkbox"/> \$2.23		<input type="checkbox"/> \$6.24		<input type="checkbox"/> \$7.78

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 12/13/10

2011 ENROLLMENT FORM

Benefit Options

Choice. Value. Health.

STATE OF ARIZONA ACTIVE 2011 ENROLLMENT FORM

2011 ENROLLMENT FORM

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

LAST NAME, FIRST NAME, M.I. <small>(USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)</small>	Date of Birth (MM/DD/YY)	Social Security Number	RELATIONSHIP CODE	MALE OR FEMALE	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER	REQUIRED	REQUIRED			A OR D	
Employee			S- Spouse C- Child D- Same-Sex Domestic Partner G- Guardian P- Placed for adoption T- Stepchild			
Spouse or Same-Sex Domestic Partner			<input type="checkbox"/> S <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> 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 visit www.benefitoptions.az.gov 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 January 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.

I DECLINE SUPPLEMENTAL LIFE INSURANCE I ELECT TO KEEP MY CURRENT SUPPLEMENTAL LIFE INSURANCE

Total amount of employee coverage: \$ _____

DEPENDENT LIFE INSURANCE

I DECLINE DEPENDENT LIFE INSURANCE I ELECT TO KEEP MY CURRENT DEPENDENT LIFE INSURANCE

<input type="checkbox"/> \$2,000	\$0.94/MONTH	Plan Code 02	<input type="checkbox"/> \$12,000	\$5.64/MONTH	Plan Code 12
<input type="checkbox"/> \$4,000	\$1.88/MONTH	Plan Code 04	<input type="checkbox"/> \$15,000	\$7.05/MONTH	Plan Code 15
<input type="checkbox"/> \$6,000	\$2.82/MONTH	Plan Code 06	<input type="checkbox"/> \$50,000	\$24.25/MONTH	Plan Code 50

Beneficiary Last Name, First Name	Date of Birth
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Beneficiary Street, City, State, Zip Code

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