



**Arizona Department of Administration  
Benefit Services Division**

## **2013 Same-Sex Domestic Partner Open Enrollment Forms and Instructions**

The documents contained herein are to assist employees and retirees enrolling a Same-Sex Domestic Partner.

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### **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 in the “Eligibility” section of the 2013 Actives and Retired Employee Guides), 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 2013 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 2013 Plan Year

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.



# Qualified Same-Sex Domestic Partner Certification Instructions

## Adding a Qualified Same-Sex Domestic Partner

To add a same-sex domestic partner:

- Complete and return the form(s) in this packet

### 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 in the “Eligibility” section of the 2013 Enrollment Guides), 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 2013 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 2013 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 (Coverage Eligibility):

- Remove the *Qualified Same-Sex Domestic Partner Affidavit* form.  
Review and complete Section I; be sure you and your domestic partner meet the criteria.
- Read and complete Section II.

### Step Two (Tax Treatment):

- Review the *Declaration of Tax Status for a Same-Sex Domestic Partner* to determine whether your qualified same-sex domestic partner fulfills the requirements to be a tax dependent.  
**Your same-sex domestic partner does not need to qualify as a tax dependent to qualify for insurance coverage, however if your same-sex domestic partner 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 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
    - Gross monthly income
    - Mortgage/ rental payment
    - 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 for a Same-Sex Domestic Partner* form.

### Step Three:

- 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
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State of \_\_\_\_\_, County of \_\_\_\_\_

Subscribed and sworn before me on this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Commission Expiration mo/day/yr

\_\_\_\_\_  
Notary Public

# Qualified Same-Sex Domestic Partner Declaration of Tax Status

I, \_\_\_\_\_, have completed a Same-Sex Qualified Domestic Partner Affidavit swearing that

\_\_\_\_\_ is my qualified same-sex domestic partner.

Print Qualified Same-Sex Domestic Partner's Name

I understand that my employer has a legitimate need to know the federal income tax status of my relationship. I understand that a same-sex domestic partner is considered a tax dependent for purposes of employer-provided health plans **only if** each of the following requirements are met:

1. My same-sex domestic partner is **NOT** 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 same-sex domestic partner 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 same-sex domestic partner and I must live together from January 1st through December 31st.

**AND**

3. My same-sex domestic partner receives more than half of his or her support from me.  
Enclosed is a Worksheet for Determining Support, similar to 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 same-sex domestic partner's support.

**AND**

4. My same-sex domestic partner 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 same-sex domestic partner is reasonably expected to be my tax dependent for the 20\_\_ calendar year.

**No**, my same-sex domestic partner is not expected to be my tax dependent for the year 20\_\_ calendar year.

As a result, premium contributions for my same-sex domestic partner cannot be taken on a pre-tax basis and the value of the benefits my employer provides for my partner 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 declared same-sex domestic partner'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 same-sex domestic partnership or 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

# 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.



# STATE OF ARIZONA ACTIVE 2013 ENROLLMENT FORM

## 2013 ENROLLMENT FORM

DATE RECEIVED

AGENCY

EFFECTIVE DATE

OPEN ENROLLMENT  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](http://www.benefitoptions.az.gov).

### MEDICAL PLANS (Employee Per Pay Period Cost Listed)

I DECLINE MEDICAL COVERAGE

#### 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"/> \$102.00
BCBSAZ/AMERIBEN EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102.00
AETNA EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102.00
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102.00

#### PPO PLANS

BCBSAZ/AMERIBEN 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"/> \$12.00		<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

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$1.86		<input type="checkbox"/> \$3.72		<input type="checkbox"/> \$3.50		<input type="checkbox"/> \$6.12
DELTA DENTAL INDEMNITY/PPO		<input type="checkbox"/> \$14.30		<input type="checkbox"/> \$30.33		<input type="checkbox"/> \$23.34		<input type="checkbox"/> \$48.26

### VISION PLAN (Employee Per Pay Period Cost Listed)

I DECLINE VISION COVERAGE

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.

## STATE OF ARIZONA ACTIVE 2013 ENROLLMENT FORM

**2013 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 \$0.69 for every \$100 of earned income per month. Please visit [www.benefitoptions.az.gov](http://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 SUPPLEMENTAL LIFE INSURANCE      Total amount of employee coverage: \$ \_\_\_\_\_

### DEPENDENT LIFE INSURANCE (Employee Per Pay Period Cost Listed)

I DECLINE DEPENDENT LIFE INSURANCE

<input type="checkbox"/> \$2,000	\$0.43	Plan Code 02	<input type="checkbox"/> \$12,000	\$2.60	Plan Code 12
<input type="checkbox"/> \$4,000	\$0.87	Plan Code 04	<input type="checkbox"/> \$15,000	\$3.25	Plan Code 15
<input type="checkbox"/> \$6,000	\$1.30	Plan Code 06	<input type="checkbox"/> \$50,000	\$11.19	Plan Code 50

### BASIC, SUPPLEMENTAL LIFE OR TRUST INFORMATION - ADDITIONAL BENEFICIARIES CAN BE ADDED ON THE STATE OF ARIZONA SUPPLEMENTAL FORM FOR BENEFICIARIES AND DEPENDENTS

Basic       Supplemental       Trust

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

#### EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify, 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. I authorize my employer to reduce my salary by applicable pre-tax dollars or reduce my paycheck by the applicable after-tax dollars for the insurance programs which I have elected. In addition, I have read and understand the declarations. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of The Affordable Care Act (ACT).

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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

# STATE OF ARIZONA BASIC AND SUPPLEMENTAL LIFE FORM FOR BENEFICIARIES AND DEPENDENTS

## EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME		EMPLOYEE ID NUMBER	DATE OF EMPLOYMENT
STREET ADDRESS		CITY, STATE	ZIP CODE
HOME TELEPHONE	WORK TELEPHONE	AGENCY NAME	AGENCY CODE

## ADDITIONAL BENEFICIARIES Basic Supplemental Trust

<b>01</b> LAST NAME, FIRST NAME		STREET ADDRESS		CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY <input type="checkbox"/> P <input type="checkbox"/> C		% OF FUNDS	SSN	PHONE NUMBER	
<b>02</b> LAST NAME, FIRST NAME		STREET ADDRESS		CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY <input type="checkbox"/> P <input type="checkbox"/> C		% OF FUNDS	SSN	PHONE NUMBER	
<b>03</b> LAST NAME, FIRST NAME		STREET ADDRESS		CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY <input type="checkbox"/> P <input type="checkbox"/> C		% OF FUNDS	SSN	PHONE NUMBER	
<b>04</b> LAST NAME, FIRST NAME		STREET ADDRESS		CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY <input type="checkbox"/> P <input type="checkbox"/> C		% OF FUNDS	SSN	PHONE NUMBER	

## TRUST OR LEGAL AGREEMENT

NAME OF TRUST, WILL OR LEGAL AGREEMENT			
ADDRESS WHERE FILED		CITY, STATE	ZIP CODE
DATE OF TRUST			

## ADDITIONAL DEPENDENTS

LAST NAME, FIRST NAME	MEDICARE A= Medicare A B= Medicare B C=Medicare A&B D= No Medicare E=Medicare Unknown	SSN	BIRTH DATE	RELATIONSHIP C=Child G=Guardian P=Placed for adoption T=Stepchild	MALE OR FEMALE	DISABLED
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N

I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including spouse/dependent information is true and correct. 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 13-2310, 12-2702 and other applicable provisions of the law.

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_