



**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:

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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:  

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

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 BENEFIT OPTIONS RETIREE/LTD 2013 OPEN ENROLLMENT FORM

**VISION PLAN SELECTION - ONLY AVAILABLE IF MEDICAL AND/OR DENTAL COVERAGE IS SELECTED**

### VISION PLAN - MONTHLY PREMIUMS AMOUNT

**DECLINE VISION COVERAGE**

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
Avesis	<input type="checkbox"/> \$4.83	<input type="checkbox"/> \$13.52	<input type="checkbox"/> \$16.86

### DENTAL PLANS - MONTHLY PREMIUMS AMOUNT

**DECLINE DENTAL COVERAGE**

Select A Plan	Retiree Only	Retiree + Adult	Retiree + Child	Retiree & Family
Delta Dental PPO plus Premier	<input type="checkbox"/> \$35.94	<input type="checkbox"/> \$75.63	<input type="checkbox"/> \$60.48	<input type="checkbox"/> \$118.26
Total Dental Administrators	<input type="checkbox"/> \$8.99	<input type="checkbox"/> \$17.98	<input type="checkbox"/> \$17.51	<input type="checkbox"/> \$26.97

### MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT

**DECLINE MEDICAL COVERAGE**

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
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#### NON MEDICARE EPO PLANS

AETNA EPO	<input type="checkbox"/> \$593.00	<input type="checkbox"/> \$1387.00	<input type="checkbox"/> \$1869.00
BCBSAZ/AMERIBEN EPO	<input type="checkbox"/> \$593.00	<input type="checkbox"/> \$1387.00	<input type="checkbox"/> \$1869.00
CIGNA EPO	<input type="checkbox"/> \$593.00	<input type="checkbox"/> \$1387.00	<input type="checkbox"/> \$1869.00
UNITEDHEALTHCARE EPO	<input type="checkbox"/> \$593.00	<input type="checkbox"/> \$1387.00	<input type="checkbox"/> \$1869.00

#### NON MEDICARE PPO PLANS

AETNA PPO	<input type="checkbox"/> \$943.00	<input type="checkbox"/> \$2219.00	<input type="checkbox"/> \$3074.00
BCBSAZ/AMERIBEN PPO	<input type="checkbox"/> \$943.00	<input type="checkbox"/> \$2219.00	<input type="checkbox"/> \$3074.00
UNITEDHEALTHCARE PPO	<input type="checkbox"/> \$943.00	<input type="checkbox"/> \$2219.00	<input type="checkbox"/> \$3074.00

#### NAU Only - Available in ALL regions NON MEDICARE

BCBS of Arizona PPO	<input type="checkbox"/> \$667.06	<input type="checkbox"/> \$1334.12	<input type="checkbox"/> \$1867.79
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**\*\*BENEFIT SERVICES DIVISION USE ONLY\*\***

PLAN NAME: \_\_\_\_\_

PLAN OPTION CODE: \_\_\_\_\_

**\*\*FOR MEMBERS WITH MEDICARE, MAKE MEDICAL ENROLLMENT SELECTIONS ON THE FOLLOWING PAGE\*\***

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD  
2013 OPEN ENROLLMENT FORM

**FOR MEMBERS WITH MEDICARE - You are required to attach a copy of your Medicare card**

I HAVE MEDICARE PART A

I HAVE MEDICARE PART B

**MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT- MEDICARE OPTIONS**

DECLINE MEDICAL COVERAGE

Select A Plan	Retiree Only with Medicare	Retiree + ONE: Both with Medicare	Retiree + ONE: One with Medicare, the other without	Retiree & Family With Medicare
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**EPO PLANS**

AETNA EPO	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$878.00	<input type="checkbox"/> \$1024.00	<input type="checkbox"/> \$1166.00
BCBSAZ/AMERIBEN EPO	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$878.00	<input type="checkbox"/> \$1024.00	<input type="checkbox"/> \$1166.00
CIGNA EPO	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$878.00	<input type="checkbox"/> \$1024.00	<input type="checkbox"/> \$1166.00
UNITEDHEALTHCARE EPO	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$878.00	<input type="checkbox"/> \$1024.00	<input type="checkbox"/> \$1166.00

**PPO PLANS**

AETNA PPO	<input type="checkbox"/> \$789.00	<input type="checkbox"/> \$1576.00	<input type="checkbox"/> \$1740.00	<input type="checkbox"/> \$1980.00
BCBSAZ/AMERIBEN PPO	<input type="checkbox"/> \$789.00	<input type="checkbox"/> \$1576.00	<input type="checkbox"/> \$1740.00	<input type="checkbox"/> \$1980.00
UNITEDHEALTHCARE PPO	<input type="checkbox"/> \$789.00	<input type="checkbox"/> \$1576.00	<input type="checkbox"/> \$1740.00	<input type="checkbox"/> \$1980.00

NAU Only - Available in ALL Regions

BCBS of Arizona PPO	<input type="checkbox"/> \$543.06	<input type="checkbox"/> \$1086.39	<input type="checkbox"/> \$1210.12	<input type="checkbox"/> \$1492.95
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***If you decline or cancel both medical and dental coverages you will NOT be able to re-enroll with ADOA in the future. If you choose to keep medical or dental coverage through ADOA, you may elect medical and/or dental coverages during future Open Enrollment periods.***

I hereby certify, under penalty of perjury, that the information provided in this application for health benefits is correct and true. I am aware that providing false information - including that which is related to my address, spouse, or dependent(s) - may subject me to denial of health benefits, disciplinary action, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws. 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 602-542-4744

**\*\*\* BENEFIT SERVICES DIVISION USE ONLY \*\*\***

PLAN NAME: \_\_\_\_\_

PLAN OPTION CODE: \_\_\_\_\_