Arizona Department of Administration
Human Resources Division, Benefit Services

2013 Same-Sex Domestic Partner 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.

Benefit Options
Choice Value Health

Revised 05/25/13

Arizona Department of Administration
Human Resources Division, Benefit Services

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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, Human Resources Division, Benefit Services
  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.

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Arizona Department of Administration
Human Resources Division, Benefit Services

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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

Revised 10/11/12

Arizona Department of Administration
Human Resources Division, Benefit Services

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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

Arizona Department of Administration
Human Resources Division, Benefit Services

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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 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 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 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
    $ _____ (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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Benefit Options
Choice Value Health

STATE OF ARIZONA
COBRA
2013 ENROLLMENT / CHANGE FORM

A1

☐ NEW ENROLLMENT ☐ QUALIFIED LIFE EVENT ☐ ADDRESS CHANGE ☐ TERMINATION

MEMBER IDENTIFICATION

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

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 SAME-SEX DOMESTIC PARTNER AFFIDAVIT FORM (this form must be notarized) with your enrollment. This form can be found on the Benefit Options website www.benefitoptions.az.gov.

MEDICAL PLANS* (Monthly Cost Listed)

☐ I DECLINE MEDICAL COVERAGE

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
EPO PLANS								
AETNA EPO		☐ $601.80		☐ $1277.04		☐ $1202.58		☐ $1658.52
BCBS of AZ/AMERIBEN EPO		☐ $601.80		☐ $1277.04		☐ $1202.58		☐ $1658.52
CIGNA EPO		☐ $601.80		☐ $1277.04		☐ $1202.58		☐ $1658.52
UNITEDHEALTHCARE EPO		☐ $601.80		☐ $1277.04		☐ $1202.58		☐ $1658.52
PPO PLANS								
AETNA PPO		☐ $913.92		☐ $1893.12		☐ $1813.56		☐ $2463.30
BCBS of AZ/AMERIBEN PPO		☐ $913.92		☐ $1893.12		☐ $1813.56		☐ $2463.30
UNITEDHEALTHCARE PPO		☐ $913.92		☐ $1893.12		☐ $1813.56		☐ $2463.30
HSA OPTION								
AETNA HSA OPTION		☐ $539.58		☐ $1134.24		☐ $1079.16		☐ $1487.16

***For the NAU Blue Cross Blue Shield plan rates visit: http:/hr.nau.edu/m/content/view/102/112/.**

DENTAL PLANS (Monthly Cost Listed)

☐ I DECLINE DENTAL COVERAGE

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		☐ $9.17		☐ $18.34		☐ $17.86		☐ $27.51
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		☐ $36.66		☐ $ 77.14		☐ $61.69		☐ $120.63

VISION PLAN (Monthly Cost Listed)

☐ I DECLINE VISION COVERAGE

SELECT A PLAN	CODE	EE ONLY		EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		☐ $4.93		☐ $13.79		☐ $17.20

ADOA USE ONLY

APPROVED ☐ **DENIED** ☐

COBRA EFF: _____ **Length of COBRA:** _____

Reviewed by:

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE

2013 COBRA ENROLLMENT FORM

Benefit Options
Choice Value Health

STATE OF ARIZONA COBRA

2013 ENROLLMENT / CHANGE FORM

A2

2013 COBRA ENROLLMENT FORM

YOUR PAYMENT TO BENEFIT OPTIONS

By law, while on COBRA coverage, you will have to pay the total cost of your COBRA coverage. You are charged the full amount of the cost for similarly-situated employees or families – both the employee's and the employer's portion - plus an additional 2% administrative fee. You must make the first payment within 45 days of notifying the plan administrator of selection of COBRA coverage. The initial payment with your enrollment needs to be sent to ADOA. Thereafter, premiums are due on the first day of each month of coverage. After your first premium payment, you may have a grace period of 30 days from the usual due date to pay the premiums.

Effective January 1, 2009, Social Security numbers (SSN) will be required for you and your 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.

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	ADD OR DELETE	INDICATE PLAN TYPE MEDICALI(M) DENTAL(D) VISION(V)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE	REQUIRED	REQUIRED			A OR D	
Employee			S- Spouse C- Child D- Same-Sex Domestic G- Guardian P- Placed for adoption T- Stepchild			
Spouse or Same-Sex 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*
			☐ C ☐ G ☐ P ☐ T	☐ M ☐ F		☐ *M* ☐ *D* ☐ *V*

EMPLOYEE AUTHORIZATION AND SIGNATURE

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, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 OR FAX TO:602-542-4744