

Same-Sex Domestic Partner's Child Declaration of Tax Status

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

I, _____, declare

_____ as my Same-Sex Domestic Partner's Child.

Print Name of Same-Sex 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 Same-Sex 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 same-sex 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 same-sex 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 same-sex domestic partner's child and I must live together from January 1st through December 31st.

AND

3. My same-sex 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 same-sex 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 same-sex domestic partner's child is reasonably expected to be my tax dependent for the 20__ calendar year.

No, my same-sex 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 same-sex domestic partner's child cannot be taken on a pre-tax basis and the value of the benefits my employer provides for my same-sex 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 same-sex 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 same-sex 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

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.

2014 ENROLLMENT / CHANGE FORM

NEW ENROLLMENT QUALIFIED LIFE EVENT ADDRESS CHANGE TERMINATION

MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.		SOCIAL SECURITY NUMBER		<input type="checkbox"/> MALE	<input type="checkbox"/> MARRIED
STREET ADDRESS		COUNTY OF RESIDENCE		<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE
CITY, STATE, ZIP CODE		WORK PHONE NUMBER ()		DATE OF BIRTH	
EMPLOYEE LAST NAME, FIRST NAME		EMAIL ADDRESS		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

EPO PLANS

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
AETNA EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
BCBS of AZ/AMERIBEN EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
CIGNA EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52

PPO PLANS

AETNA PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30
BCBS of AZ/AMERIBEN PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30

HSA OPTION

AETNA HSA OPTION		<input type="checkbox"/> \$539.58		<input type="checkbox"/> \$1134.24		<input type="checkbox"/> \$1079.16		<input type="checkbox"/> \$1487.16
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*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		<input type="checkbox"/> \$9.17		<input type="checkbox"/> \$18.34		<input type="checkbox"/> \$17.86		<input type="checkbox"/> \$27.51
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$36.66		<input type="checkbox"/> \$77.14		<input type="checkbox"/> \$61.69		<input type="checkbox"/> \$120.63

VISION PLAN (Monthly Cost Listed)

I DECLINE VISION COVERAGE

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		<input type="checkbox"/> \$4.93		<input type="checkbox"/> \$13.79		<input type="checkbox"/> \$17.20

ADOA USE ONLY

APPROVED **DENIED**

COBRA EFF: _____ Length of COBRA: _____

Reviewed by:

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE
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2014 COBRA ENROLLMENT FORM

2014 ENROLLMENT / CHANGE 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. <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	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			<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
			<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

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

2014 COBRA ENROLLMENT FORM