



# 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  
2014 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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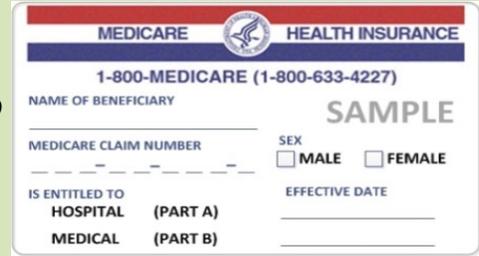
**\*\*BENEFIT SERVICES DIVISION USE ONLY\*\***

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

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

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

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



MEDICARE HEALTH INSURANCE  
1-800-MEDICARE (1-800-633-4227)  
NAME OF BENEFICIARY: SAMPLE  
MEDICARE CLAIM NUMBER: \_\_\_\_\_ SEX:  MALE  FEMALE  
IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B) EFFECTIVE DATE: \_\_\_\_\_

I HAVE MEDICARE PART A

I HAVE MEDICARE PART B

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

**ACCEPT MEDICAL COVERAGE** - Medicare becomes primary for medical coverage and includes Medicare Part D prescription drug coverage. I understand that if I lose my prescription drug coverage, I will also lose my medical coverage.

**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
<b>EPO PLANS</b>				
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
<b>PPO PLANS</b>				
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

- 1. If you decline or cancel both medical and dental coverages you will NOT be able to re-enroll with ADOA in the future.**
- 2. If you choose to keep medical or dental coverage through ADOA, you may elect medical and/or dental coverages during future Open Enrollment periods.**
- 3. If you are eligible for Medicare, your medical coverage will include prescription drug coverage in a Medicare Part D plan with additional coverage provided by the State of Arizona.**
- 4. If you are enrolled in another Medicare prescription drug plan or individual Medicare Advantage plan – with or without prescription drug coverage – you will be disenrolled from that coverage. If you enroll in these plans after you are enrolled in the State of Arizona’s plan, you will be disenrolled from the State of Arizona plan.**
- 5. If you are disenrolled or otherwise leave the State of Arizona prescription drug plan, you will lose both your medical and prescription drug coverage.**

**STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD  
2014 ENROLLMENT FORM**

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 Resources Division, Benefit Services, 100 N. 15th Ave., Suite 103  
Phoenix, AZ 85007 or Fax 602-542-4744

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

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

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