

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

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

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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.



# STATE OF ARIZONA ACTIVE 2014 ENROLLMENT FORM

**2014 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<br><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 |
|-----------|--|----------------------------------|--|----------------------------------|--|----------------------------------|--|----------------------------------|

### 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.

REVISED 06/17/2013



## STATE OF ARIZONA ACTIVE 2014 ENROLLMENT FORM

**2014 ENROLLMENT FORM**
**DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans**

| LAST NAME, FIRST NAME, M.I.<br><small>(USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)</small> | DATE OF BIRTH<br>(MM/DD/YY) | SOCIAL SECURITY NUMBER | RELATIONSHIP CODE  | MALE OR FEMALE  | ADD OR DELETE | INDICATE PLAN TYPE<br>MEDICAL (M) DENTAL (D)<br>VISION (V)                       |
|---|-----------------------------|------------------------|--|---|---------------|--|
| LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER  | REQUIRED                    | REQUIRED               |  |   | A OR D        |  |
| Employee  |                             |                        | S- Spouse<br>C- Child<br>D- Same-Sex Domestic Partner<br>G- Guardian<br>P- Placed for adoption<br>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 |

|   |                           |                 |                            |
|---|---------------------------|-----------------|----------------------------|
| Beneficiary Last Name, First Name         | Beneficiary Date of Birth | Beneficiary SSN | Beneficiary Contact Number |
| 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 Human Resources Division-Benefit Services, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 Or fax to: 602-542-4744

# STATE OF ARIZONA SUPPLEMENTAL 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

|  |                |             |              |
|--|----------------|-------------|--------------|
| 01 LAST NAME, FIRST NAME   | STREET ADDRESS | CITY, STATE | ZIP CODE     |
| PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY<br><input type="checkbox"/> P <input type="checkbox"/> C | % OF FUNDS     | SSN         | PHONE NUMBER |
| 02 LAST NAME, FIRST NAME   | STREET ADDRESS | CITY, STATE | ZIP CODE     |
| PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY<br><input type="checkbox"/> P <input type="checkbox"/> C | % OF FUNDS     | SSN         | PHONE NUMBER |
| 03 LAST NAME, FIRST NAME   | STREET ADDRESS | CITY, STATE | ZIP CODE     |
| PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY<br><input type="checkbox"/> P <input type="checkbox"/> C | % OF FUNDS     | SSN         | PHONE NUMBER |
| 04 LAST NAME, FIRST NAME   | STREET ADDRESS | CITY, STATE | ZIP CODE     |
| PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY<br><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<br>A= Medicare A<br>B= Medicare B<br>C=Medicare A&B<br>D= No Medicare<br>E=Medicare<br>Unknown | SSN | BIRTH DATE | RELATIONSHIP<br>C=Child<br>G=Guardian<br>P=Placed for<br>adoption<br>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:** \_\_\_\_\_