



BENEFITS ENROLLMENT—WITH DOMESTIC PARTNER FAX to 480.993.0007

For Benefits through Sept. 30, 2009

Process for adding a Qualified Domestic Partner

1. Review the Declaration of Tax Status Form to determine whether your qualified domestic partner fulfills the requirements to be a tax dependent.
2. If you are unsure whether your domestic partner meets the support requirement for dependent status, you may confirm eligibility by using the optional Worksheet for Determining Support form. Keep the worksheet for your personal records. You do not need to return the worksheet with the other forms.
3. Complete Domestic Partner Affidavit. This document must be notarized.
4. In addition to the Affidavit you will need to provide at least three of the following documents to show that each person is financially interdependent in at least three of the following ways:
 - 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 (i.e. durable power of attorney);
 - g. Other proof of financial interdependence as approved by the Director;
5. Complete Domestic Partner Declaration of Tax Status form.
6. Complete the attached enrollment form.
7. Sign and date, and then print your Employee ID Number on the Declaration of Tax Status for a Domestic Partner form.

SUBMIT THE FORMS

Submit all completed forms and supporting documentation to:
**Office of Human Resources
Benefits Design & Management**
Confidential E-fax
480.993.0007

**Qualified Domestic Partner
Affidavit**



SECTION I:

I, _____ certify that _____ and I are domestic
Name of employee or retiree (print) Name of 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:
 - 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 domestic partner or by a change of circumstance attested to in the *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 *Domestic Partnership Change Form* .
- B. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a *Statement of 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

**SEND TO ASU BENEFITS CONFIDENTIAL
E-FAX AT 480.993.0007**

Qualified Domestic Partner Declaration of Tax Status

SEND TO ASU BENEFITS CONFIDENTIAL EFAX: 480.993.0007



I, _____ have completed a Qualified Domestic Partner

Affidavit swearing that _____ is my qualified domestic partner.
PRINT QUALIFIED 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 domestic partner is considered a tax dependent for purposes of employer-provided health plans **ONLY IF** each of the following requirements are met:

My 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

My 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 domestic partner and I must live together from Jan. 1 through Dec. 31.

AND

My domestic partner 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 Publication 17, that you can use to determine whether you provide, or expect to provide, more than half of your domestic partner's support.

AND

My 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 below. Since the above is the 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 domestic partner is reasonably expected to be my tax dependent for the 20__ calendar year.

No, my domestic partner is not expected to be my tax dependent for the 20__ calendar year.

As a result, premium contributions for my 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 benefits rules, I may be liable for any claims paid by my health plan(s) or premiums paid on my behalf and my declared 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 attorney's fees, if I have made a false statement in this declaration.

I must notify my benefits office if there is a change in the 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 (mm/dd/yy)



BENEFITS ENROLLMENT with DOMESTIC PARTNER

3-page form | **FAX to 480.993.0007**

For Benefits through Sept. 30, 2009

EMPLOYEE INFORMATION		Date Received: _____		Effective Date: _____	
LAST NAME, FIRST NAME, MI		EMPLOYEE EIN	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	
STREET ADDRESS		COUNTY OF RESIDENCE	DATE OF BIRTH	DATE OF HIRE	
CITY/STATE/ZIP		WORK PHONE (include area code)	HOME PHONE (include area code)		
Have you recently transferred from an Arizona state agency, University of Arizona (UofA), Northern Arizona University (NAU) or Arizona Board of Regents?		<input type="checkbox"/> NO <input type="checkbox"/> YES	If YES, from where: _____	ID at previous employer: _____	
Are you enrolling a Domestic Partner?		YES	NO		
Do You Claim your Domestic Partner on your IRS tax return?		YES	NO		
Are you enrolling an Older Child(ren) that is/are neither a full-time student(s) nor disabled dependent(s)?		YES	NO		
Do you claim your Older Child(ren) on your IRS tax return?		YES	NO		
<p>To qualify a Domestic Partner, you will need to complete and submit the DOMESTIC PARTNER AFFIDAVIT FORM (this form must be notarized) and the DECLARATION OF TAX STATUS FORM and submit the form with your enrollment. To qualify as an Older Child (age 19-24 and neither a full-time student nor a disabled dependent), the Older Child have been covered on an ADOA plan at the age of 18 years age (see the Enrollment Guide for qualifications of an Older Child). You will need to complete and submit the DECLARATION OF TAX STATUS FORM and submit the form with your enrollment. These forms can be found on the BENEFITS HR FORMS PAGE at www.asu.edu/hr/forms. It is your responsibility, as an employee, to determine whether a dependent is considered a PRE-TAX or POST-TAX dependent for purposes of determining whether imputed income will apply. Please consult a tax advisor before you certify that your Domestic Partner or Older Child is a PRE-TAX or POST-TAX dependent. Notice of any change in dependent tax status must be communicated to ADOA within 31 days of the change.</p>					
MEDICAL PLANS (Employee Monthly Cost Listed)		<input type="checkbox"/> I DECLINE MEDICAL COVERAGE.			
COUNTIES: Gila, Maricopa, Pima, Pinal, Santa Cruz					
SELECT A PLAN		TIER 1 (Employee)	TIER 2 (Employee + 1)	TIER 3 (Family)	
RAN+AMN (HMA) EPO		<input type="checkbox"/> \$30	<input type="checkbox"/> \$60	<input type="checkbox"/> \$150	
United HealthCare (UHC) EPO		<input type="checkbox"/> \$30	<input type="checkbox"/> \$60	<input type="checkbox"/> \$150	
Arizona Foundation (AZF) PPO		<input type="checkbox"/> \$145	<input type="checkbox"/> \$290	<input type="checkbox"/> \$415	
United HealthCare (UHC) PPO		<input type="checkbox"/> \$145	<input type="checkbox"/> \$290	<input type="checkbox"/> \$415	
All Other Counties					
RAN+AMN (HMA) EPO		<input type="checkbox"/> \$30	<input type="checkbox"/> \$60	<input type="checkbox"/> \$150	
Arizona Foundation (AZF) PPO		<input type="checkbox"/> \$145	<input type="checkbox"/> \$290	<input type="checkbox"/> \$415	
Out-of-State					
Beech Street PPO		<input type="checkbox"/> \$30	<input type="checkbox"/> \$60	<input type="checkbox"/> \$150	
DENTAL PLANS (Employee Monthly Cost Listed)		<input type="checkbox"/> I DECLINE DENTAL COVERAGE.			
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$5	<input type="checkbox"/> \$9	<input type="checkbox"/> \$14	
DELTA DENTAL INDEMNITY/PPO in Arizona and Out-of-State		<input type="checkbox"/> \$16	<input type="checkbox"/> \$37	<input type="checkbox"/> \$63	
EMPLOYEE NAME:			EIN:		



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VISION PLAN (Employee Monthly Cost Listed)	<input type="checkbox"/> I DECLINE VISION COVERAGE.
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	TIER 1 (Employee)	TIER 3 (Family)
AVESIS VISION COVERAGE	<input type="checkbox"/> \$6.34	<input type="checkbox"/> \$17.18

DEPENDENTS

List ALL eligible dependents to be enrolled or disenrolled in medical, dental and/or vision plans

NOTE: List LAST NAME if different from employee

RELATIONSHIP CODES: S Spouse | C Child | D Domestic Partner | G Guardian | P Placed for Adoption | OC Older Child

NAME Last/First/MI Use additional form if needed	BIRTH DATE (mm/dd/yy)	SOCIAL SECURITY NUMBER (REQUIRED)	RELATIONSHIP	MALE OR FEMALE M or F	FULL-TIME STUDENT Y or N	DISABLED Y or N	ADD OR DELETE A or D	PLAN TYPE MEDICAL (M) DENTAL (D) VISION (V)
EMPLOYEE								
SPOUSE								
DOMESTIC PARTNER								

OTHER DEPENDENTS

PRIMARY BENEFICIARY – For additional beneficiaries, attach a separate sheet **PRIMARY % MUST = 100%**

#1 Beneficiary Last Name, First Name:	Payment %:
Social Security Number (REQUIRED):	
Address:	
Phone:	
Relationship:	
Date of Birth:	
#2 Beneficiary Last Name, First Name:	
Social Security Number (REQUIRED):	
Address:	
Phone:	
Relationship:	
Date of Birth:	



EMPLOYEE NAME:		EIN:	
CONTINGENT BENEFICIARY – For additional beneficiaries, attach a separate sheet		CONTINGENT % MUST = 100%	
#1 Beneficiary Last Name, First Name:		Payment %:	
Social Security Number (REQUIRED):			
Address:			
Phone:			
Relationship:			
Date of Birth:			
#2 Beneficiary Last Name, First Name:		Payment %:	
Social Security Number (REQUIRED):			
Address:			
Phone:			
Relationship:			
Date of Birth:			
SHORT-TERM DISABILITY			
Standard	<input type="checkbox"/> DECLINE	<input type="checkbox"/> ELECT	
Unum	<input type="checkbox"/> DECLINE	<input type="checkbox"/> Option A	<input type="checkbox"/> Option B <input type="checkbox"/> Option C
STANDARD EMPLOYEE SUPPLEMENTAL LIFE INSURANCE		STANDARD DEPENDENT LIFE INSURANCE	
<input type="checkbox"/> I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE		<input type="checkbox"/> I DECLINE DEPENDENT LIFE COVERAGE	
<input type="checkbox"/> I Elect coverage in the amount of \$ _____ ((\$5000 increments)		I Elect coverage in the amount of:	
<input type="checkbox"/> I am a NON-SMOKER for the last 6 months (additional \$1000 benefit)		<input type="checkbox"/> \$2,000 \$0.94/month	<input type="checkbox"/> \$12,000 \$5.64/month
<input type="checkbox"/> NO CHANGE		<input type="checkbox"/> \$4,000 \$1.88/month	<input type="checkbox"/> \$15,000 \$7.06/month
		<input type="checkbox"/> \$6,000 \$2.82/month	<input type="checkbox"/> NO CHANGE
AETNA SUPPLEMENTAL LIFE INSURANCE			
<input type="checkbox"/> I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE			
<input type="checkbox"/> OPTION A (1x Annual Salary)		<input type="checkbox"/> OPTION C (3x Annual Salary)	
<input type="checkbox"/> OPTION B (2x Annual Salary)		<input type="checkbox"/> NO CHANGE	
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, 12-2311, 12-2702 and other applicable provisions of the law. In addition, I have read and understand the declarations.			
SIGNATURE		DATE	
FAX TO 480.993.0007			