



## Process for adding a Qualified Domestic Partner's Child

1. Complete and return the form(s) in this packet. You must complete a separate Declaration of Tax Status form for each Domestic Partner child you are adding.
  - a. Domestic Partner's Child Declaration of Tax Status form
  - b. Benefits Enrollment Form
2. Review the Declaration of Tax Status form for the Domestic Partner's Child to determine whether your Domestic Partner's Child fulfills the requirements to be a tax dependent.
3. If you are unsure whether your domestic partner's child meets the support requirement for dependent status, you may confirm eligibility by using the optional Worksheet for Determining Support form.
  - I. If completing the optional Worksheet for Determining Support, you will need to know your qualified domestic partner's child's:
    - a. Gross monthly income, if any,
    - b. Mortgage / rental payment, if any,
    - c. Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
  - II. Keep the worksheet for your personal records. You do not need to return the worksheet with the other forms.
4. Sign and date, and then print your Employee ID Number on the Declaration of Tax Status 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



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

### **Domestic Partner's Child Declaration of Tax Status**

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

I, \_\_\_\_\_, declare

\_\_\_\_\_ as my Domestic Partner's Child.  
Print Name of 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 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 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 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 domestic partner's child and I must live together from January 1st through December 31st.

**AND**

3. My 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 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 domestic partner's child is reasonably expected to be my tax dependent for the 20\_\_ calendar year.
- No**, my 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 domestic partner's child cannot be taken on a pre-tax basis and the value of the benefits my employer provides for my 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 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 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





<b>EMPLOYEE INFORMATION</b>		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 <a href="http://www.asu.edu/hr/forms">www.asu.edu/hr/forms</a>. 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>					
<b>MEDICAL PLANS (Employee Monthly Cost Listed)</b>		<input type="checkbox"/> <b>I DECLINE MEDICAL COVERAGE.</b>			
COUNTIES: Gila, Maricopa, Pima, Pinal, Santa Cruz					
<b>SELECT A PLAN</b>		<b>TIER 1 (Employee)</b>	<b>TIER 2 (Employee + 1)</b>	<b>TIER 3 (Family)</b>	
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	
<b>All Other Counties</b>					
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	
<b>Out-of-State</b>					
Beech Street PPO		<input type="checkbox"/> \$30	<input type="checkbox"/> \$60	<input type="checkbox"/> \$150	
<b>DENTAL PLANS (Employee Monthly Cost Listed)</b>		<input type="checkbox"/> <b>I DECLINE DENTAL COVERAGE.</b>			
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	
<b>EMPLOYEE NAME:</b>			<b>EIN:</b>		



<b>VISION PLAN (Employee Monthly Cost Listed)</b>	<input type="checkbox"/> <b>I DECLINE VISION COVERAGE.</b>
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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 <b>(REQUIRED)</b>	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%**

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



EMPLOYEE NAME:		EIN:	
CONTINGENT BENEFICIARY – For additional beneficiaries, attach a separate sheet		<b>CONTINGENT % MUST = 100%</b>	
<b>#1 Beneficiary Last Name, First Name:</b>		Payment %:	
Social Security Number <b>(REQUIRED):</b>			
Address:			
Phone:			
Relationship:			
Date of Birth:			
<b>#2 Beneficiary Last Name, First Name:</b>		Payment %:	
Social Security Number <b>(REQUIRED):</b>			
Address:			
Phone:			
Relationship:			
Date of Birth:			
<b>SHORT-TERM DISABILITY</b>			
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
<b>STANDARD EMPLOYEE SUPPLEMENTAL LIFE INSURANCE</b>		<b>STANDARD DEPENDENT LIFE INSURANCE</b>	
<input type="checkbox"/> <b>I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE</b>		<input type="checkbox"/> <b>I DECLINE DEPENDENT LIFE COVERAGE</b>	
<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
<b>AETNA SUPPLEMENTAL LIFE INSURANCE</b>			
<input type="checkbox"/> <b>I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE</b>			
<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	
<b>EMPLOYEE AUTHORIZATION AND SIGNATURE</b>			
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	
<b>FAX TO 480.993.0007</b>			