



**2009-2010 BENEFITS ENROLLMENT
—WITH DOMESTIC PARTNER
FAX to 480.993.0007**

Use for Benefits that take effect Oct. 1, 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)



2009-2010 BENEFITS ENROLLMENT (NEW HIRES)

3-page form | **FAX to 480.993.0007** For Benefits effective Oct. 1, 2009

<input type="checkbox"/> NEW EMPLOYEE	<input type="checkbox"/> QUALIFIED LIFE EVENT	<input type="checkbox"/> AGENCY TRANSFER AGENCY NAME _____	
EMPLOYEE IDENTIFICATION		DATE RECEIVED: _____	
LAST NAME, FIRST NAME, MI	EMPLOYEE EIN or SSN	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
STREET ADDRESS	COUNTY OF RESIDENCE	BIRTHDATE	DATE OF HIRE
CITY/STATE/ZIP	WORK PHONE # ()	HOME PHONE # ()	
Are you enrolling a Domestic Partner (Circle One):		YES	NO
Do you claim your Domestic Partner on your IRS Tax Return (Circle One):		YES	NO
Are you enrolling an Older Child(ren) that is/are neither a full-time student(s) nor disabled dependent(s) (Circle One):		YES	NO
Do you claim your Child(ren) on your IRS Tax Return (Circle One):		YES	NO
<p>If you have already enrolled a qualified domestic partner or older child, you do not need to submit additional paperwork. If you want to add a domestic partner or older child during open enrollment, please visit BENEFITS ONLINE for info: Domestic Partner and Children coverage: www.asu.edu/hr/benefits/dompartnerandchildren.html Older Children coverage: www.asu.edu/hr/benefits/olderchildcoverage.html</p>			
MEDICAL PLANS (Employee Monthly Cost Listed)		<input type="checkbox"/> I DECLINE MEDICAL COVERAGE.	
EPO PLANS	EE ONLY	EE + ADULT	EE + CHILD
AETNA CHOICE II (Open Access)	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46
AMERIBEN	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46
CIGNA OPEN ACCESS PLUS ONLY	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46
UNITED HEALTHCARE SELECT	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46
PPO PLANS	EE ONLY	EE + ADULT	EE + CHILD
AETNA SELECT (Open Access)	<input type="checkbox"/> \$71.08	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62
AMERIBEN	<input type="checkbox"/> \$71.06	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62
UNITED HEALTHCARE OPTIONS	<input type="checkbox"/> \$71.06	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62
HSA OPTION WITH HEALTHFUND HASs —Cost will be PLUS HealthFund Election			
AETNA CHOICE POS II	<input type="checkbox"/> \$11.54+	<input type="checkbox"/> \$36.92+	<input type="checkbox"/> \$27.23+
DENTAL PLANS (Employee Monthly Cost Listed)		<input type="checkbox"/> I DECLINE DENTAL COVERAGE.	
	SINGLE	EE + 1	EE + FAMILY
DELTA DENTAL	<input type="checkbox"/> \$13.78	<input type="checkbox"/> \$31.35	<input type="checkbox"/> \$54.52
TOTAL DENTAL ADMINISTRATORS	<input type="checkbox"/> \$2.31	<input type="checkbox"/> \$4.15	<input type="checkbox"/> \$6.46
VISION PLANS (Employee Monthly Cost Listed)		<input type="checkbox"/> I DECLINE VISION COVERAGE.	
AVESIS ADVANTAGE	<input type="checkbox"/> \$2.23	<input type="checkbox"/> \$6.24	<input type="checkbox"/> \$7.78
AVESIS DISCOUNT PROGRAM			
If you waive the Advantage Program coverage, you will be automatically enrolled in the Discount Program and will get an Avesis discount card at no charge.			
EMPLOYEE NAME:		EIN/SSN:	
EFFECTIVE JAN. 1, 2009 All active state employees MUST provide social security numbers (SSNs) for all enrolled dependents.			



2009-2010 BENEFITS ENROLLMENT (NEW HIRES)

3-page form | **FAX to 480.993.0007** For Benefits effective Oct. 1, 2009

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 are to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performing 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 has a long-standing practice of requesting SSNs or HICNs for coordination of benefit purposes.

DEPENDENTS

List ALL eligible dependents to be enrolled or unenrolled 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

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

CONTINGENT % MUST = 100%

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

CONTINGENT BENEFICIARY

CONTINGENT % MUST = 100%

#1 Beneficiary Last Name, First Name:		Payment %:
Social Security Number (OPTIONAL):		
Address:		
Phone:		
Relationship:		



2009-2010 BENEFITS ENROLLMENT (NEW HIRES)

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

SHORT-TERM DISABILITY

The Hartford	<input type="checkbox"/> DECLINE	<input type="checkbox"/> ELECT		
Unum Provident Short-term Disability	<input type="checkbox"/> DECLINE	<input type="checkbox"/> OPTION A	<input type="checkbox"/> OPTION B	<input type="checkbox"/> OPTION C

THE HARTFORD EMPLOYEE SUPPLEMENTAL LIFE INSURANCE		THE HARTFORD 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) up to three times your annual salary or \$300,000, whichever is less		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"/> \$2000 \$0.94/month	<input type="checkbox"/> \$12,000 \$5.64/month
<input type="checkbox"/> NO CHANGE		<input type="checkbox"/> \$4000 \$1.88/month	<input type="checkbox"/> \$15,000 \$7.06/month
		<input type="checkbox"/> \$6000 \$2.82/month	<input type="checkbox"/> \$50,000 \$24.25/month
		<input type="checkbox"/> NO CHANGE	

AETNA EMPLOYEE SUPPLEMENTAL LIFE INSURANCE		AETNA 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 \$ _____ 1, 2 OR 3 times my annual salary or \$500,000, whichever is less, without evidence of good health. Amounts \$500,000 to \$1 million require evidence of good health.		Spouse \$5,000 / Child(ren) \$2500	\$1.05/pay period \$2.28/month
<input type="checkbox"/> I am a NON-SMOKER for the last 6 months		Spouse \$10,000 / Child(ren) \$5,000	\$3.16/pay period \$6.84/month
<input type="checkbox"/> NO CHANGE		Spouse \$25,000 / Child(ren) \$12,500	\$5.26/pay period \$11.39/month
		Spouse \$50,000* / Child(ren) \$25,000 Requires Evidence of Good Health	\$10.52/pay period \$22.79/month
		<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