



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



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	EE + FAMILY	
AETNA CHOICE II (Open Access)	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46	<input type="checkbox"/> \$82.15	
AMERIBEN	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46	<input type="checkbox"/> \$82.15	
CIGNA OPEN ACCESS PLUS ONLY	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46	<input type="checkbox"/> \$82.15	
UNITED HEALTHCARE SELECT	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46	<input type="checkbox"/> \$82.15	
PPO PLANS	EE ONLY	EE + ADULT	EE + CHILD	EE + FAMILY	
AETNA SELECT (Open Access)	<input type="checkbox"/> \$71.08	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62	<input type="checkbox"/> \$204.46	
AMERIBEN	<input type="checkbox"/> \$71.06	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62	<input type="checkbox"/> \$204.46	
UNITED HEALTHCARE OPTIONS	<input type="checkbox"/> \$71.06	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62	<input type="checkbox"/> \$204.46	
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+	<input type="checkbox"/> \$69.23+	
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.					



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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:		



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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