



DEPARTMENT OF ADMINISTRATION

Office of Employee Benefits

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Providence, RI 02908-5890

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DOMESTIC PARTNER DEPENDENT DECLARATION FORM

This form must be completed and signed by the employee when enrolling a domestic partner in the state employee health plan.

If your domestic partner does not meet the definition of a dependent pursuant to Internal Revenue Code Section 152 (as modified by Section 105(b)), federal law requires that the fair market value of the coverage extended to your domestic partner must be imputed to you as income on your paycheck and must be reflected on the W-2 issued to you by the State of Rhode Island.

Name of Employee: _____
(Print full name)

Name of Domestic Partner: _____
(Print full name)

SECTION 1.

(a) My domestic partner lives with me and is a member of my household.

____ Yes ____ No

(b) My domestic partner receives over one-half of his or her support from me.

____ Yes ____ No

(c) My domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico at some time during the calendar year in which I am claiming him or her as a dependent.

____ Yes ____ No

(d) My domestic partner can be claimed as a “qualifying child” by someone else. (Generally, a qualifying child is a dependent under age 19 (age 24 if a full-time student) that meets certain IRS requirements).

____ Yes ____ No

The Rhode Island State Employee Health Plan complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services, free of charge, are available to you. Call (401) 222-3160.

If you have answered “Yes” to questions (a), (b) and (c), and “No” to question (d), complete Section 2.

For all other responses, complete Section 3.

SECTION 2. CERTIFICATION – Meets IRS Requirements

I, _____ hereby certify that I have answered the applicable questions truthfully and certify to the Plan Administrator that my domestic partner does meet the definition of a dependent pursuant to Section 152 (as modified by Section 105(b)) of the Internal Revenue Code. I understand that falsely certifying to the tax-dependent status of my domestic partner may result in adverse tax consequences and potential charges of tax fraud.

Employee’s signature: _____ Date: _____

SECTION 3. CERTIFICATION – Does Not Meet IRS Requirements

I, _____ hereby certify that I have answered the applicable questions truthfully and certify to the Plan Administrator that my domestic partner does not meet the definition of a dependent pursuant to Section 152 (as modified by Section 105(b)) of the Internal Revenue Code.

Since my domestic partner does not meet the definition of a dependent pursuant to Section 152 (as modified by Section 105(b)) of the Internal Revenue Code, the fair market value of the coverage extended to my domestic partner will be imputed to me as income on my paycheck and will be reflected on the W-2 issued to me by the State of Rhode Island.

Employee’s signature: _____ Date: _____

YOU SHOULD KEEP A COPY OF THIS CERTIFICATION WITH YOUR BENEFITS INFORMATION AND RETURN THE ORIGINAL COMPLETED FORM TO THE OFFICE OF EMPLOYEE BENEFITS.

THIS DECLARATION FORM SHALL REMAIN ON FILE AND WILL APPLY IN SUBSEQUENT YEARS – UNLESS YOU FILE A NEW DECLARATION FORM. YOU WILL HAVE AN OPPORTUNITY TO COMPLETE A NEW DECLARATION FORM DURING EACH OPEN ENROLLMENT PERIOD.

IN THE EVENT THAT THERE IS A CHANGE IN THE FUTURE WHICH WOULD AFFECT AN ANSWER TO A QUESTION ON THIS FORM, SUCH AS A CHANGE IN SUPPORT (i.e., your dependent domestic partner no longer receives over one-half of his/her support from you), YOU ARE REQUIRED TO INFORM THE OFFICE OF EMPLOYEE BENEFITS IN WRITING IMMEDIATELY.

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