Domestic Partner Certification for Dependent Tax Status

General Information
Use this form if you are an active employee and want to certify that your domestic partner or domestic partner’s children qualify as dependents for the purpose of pre-tax health benefits.

Domestic Partners Eligible for Health Coverage
Group health coverage, including medical and dental benefits, is available for domestic partners of the State of Oregon’s eligible employees. Refer to the applicable summary plan description (SPD) and enrollment materials for a definition of domestic partner, the procedures you must follow to enroll your domestic partner for coverage.

Tax Consequences of Domestic Partner Coverage
Under federal tax law, if your (non-spouse) domestic partner does not qualify as your tax dependent for health coverage purposes (as defined below), then the value of your domestic partner’s coverage will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported on your Form W-2. This includes any portion of the premiums that your employer pays for your domestic partner’s health coverage. (The value of coverage varies, depending on the medical and dental coverage options you elect)

If your domestic partner qualifies as your tax dependent for health coverage purposes, then no portion of the premiums paid by your employer will be included in your income or be subject to federal withholding or employment taxes.

Filing a Certification of Dependent of Domestic Partner Status
If your domestic partner qualifies as your tax dependent for health coverage purposes, you can avoid having the value of your domestic partner’s health coverage treated as taxable income. To avoid taxation, you must complete and return this Certification of Dependent Domestic Partner Status, indicating that your domestic partner qualifies as your federal tax dependent for health coverage purposes. Because the determination of whether a person is a tax dependent for health coverage purposes turns on facts solely within your knowledge, your employer cannot make this determination for you. You should make this determination in consultation with your tax professional. You must complete a Certification each year during open enrollment. This form must be to your payroll/benefit office before January 1st of a new plan year. For any year in which your employer does not receive a Certification from you, your employer will assume that your domestic partner does not qualify as your federal tax dependent for health coverage purposes for that year.

Dependent Domestic Partner’s Name: ____________________________ Birth date: __________

List each Domestic Partner’s child to be certified as a tax dependent:

____________________________________ Birth date: __________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________

Office use only

Approved by: __________________________
Approved date: _________________________
Effective date: _________________________
I agree to notify my employer in writing as soon as possible if there is a change in any of the above persons’ status as my tax dependent for health coverage purposes, including any change that may occur midyear. **I understand that any change in such status may result in the retroactive application of taxes to amounts previously paid for health coverage during the year.**

I understand that on the basis of the above statements, my employer will decide whether to treat the above person as my tax dependent for all federal income and employment tax purposes, and that if I fail to complete this Certification or any recertification requested by my employer, then my employer will assume that the person does not qualify as my federal tax dependent for health coverage purposes.

I agree to reimburse my employer for any and all taxes, penalties, or other losses (including reasonable attorneys’ fees) that my employer may incur as a result of its reliance on this Certification if it is untrue or incorrect in any respect, or if I fail to provide the notice required above.

**I understand that:**

- A person knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines.

- Knowingly making a false statement may subject me to termination of enrollment, denial of future enrollment, or civil damages.

- If I fail to report a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member’s coverage retroactively, pursuant to PEBB rules.

You must submit a midyear change form to your benefit office within 30 days of the date when an individual you provide coverage for is no longer PEBB eligible. If your notice is late, you and your qualified beneficiaries may lose the right to elect COBRA.

☐ I hereby certify that the above statements are true and correct. A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment or fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

Signature: ___________________________ Date: ___________________________

Type or print name: ___________________________

Submit completed form to your agency payroll or university benefits office.

Keep a copy of your benefit forms for your records.

Any alteration of this form may result in it being ineffective.

Note: You must submit this form each year to certify your Domestic Partner and/or Domestic Partner’s Children as Dependents.