Domestic Partner Certification for Dependent Tax Status form

Employee Name: _____ Employee #: _____

Domestic Partner, as used in this document, shall apply to all Domestic Partners.
Under federal tax law, if your Domestic Partner and partner's child(ren) do not qualify as your tax dependent for health coverage purposes, then the value of the partner coverage will be included in your gross income.

Use this form if you want to certify that your Domestic Partner or Domestic Partner's child(ren) qualify as current Federal tax dependents for the purpose of pre-tax health benefits. This form must be completed annually to avoid taxation. 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. 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.

The below dependents are certified as a tax dependent:
Domestic Partner's Name: _____
Domestic Partner's child Name: _____
Domestic Partner's child Name: _____
Domestic Partner's child Name: _____

I understand that:

- I will notify my employer in writing within 30 days if there is a change in any of the above persons' status as my federal tax dependent or is no longer eligible for health coverage, including any change that may occur midyear. If your notice is late, you and your dependents may lose the right to elect COBRA.
- If I fail to report a change that made an enrolled family member ineligible, City of Salem may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, City of Salem may terminate the family member's coverage retroactively, pursuant to City of Salem rules.
- Any change in such status may result in the retroactive application of taxes to amounts previously paid for health coverage during the year.
- On the basis of the above statement, 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.
- A person who knowingly makes a false statement may be subject to termination of enrollment, denial of future enrollment, civil damages, imprisonment and fines.
- Domestic partner and children of partner's are subject to verification.
- I hereby certify that the above statements are true and correct.
- 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.

Employee Signature: _____ Date: _____

HR Representative Signature: _____ Date: _____