pebb
Public Employees' Benefit Board

Domestic Partner Certification for Dependent Tax Status

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

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 current Federal tax 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, and 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, vision and dental coverage options you select.)

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 Tax Status

To avoid taxation, you must complete and return this Certification of Dependent Tax 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 returned to your agency/university payroll office before January 1, 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.

Each of the following dependents you list must also have an appropriate Affidavit (Child, Grandchild and/or Domestic Partner) on file with PEBB. See https://www.oregon.gov/OHA/PEBB/Pages/forms.aspx

Domestic Partner's Name: _____ Date of birth: _____

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

_____ Date of birth: _____

_____ Date of birth: _____

_____ Date of birth: _____

Employee signature and authorization

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, 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.
- 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 may be subject to verification by PEBB.

☐ 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.

Signature:_____ Date:_____

Type or print name:_____

Submit completed form to your agency or university payroll office.
Keep a copy of your benefit forms for your records.
Any alteration of this form may result in it being ineffective.