IOWA
Department of Administrative Services

# Declaration of Domestic Partnership

| | Last Name | First Name | MI | Date of Birth | Last Four Digits of SSN: |
|---|---|---|---|---|---|
| **Employee** | | | | | |
| **Domestic Partner** | | | | | |

Complete the following if adding eligible dependents of the Domestic Partner. Please do **NOT** include your biological children.

| Eligible dependents of the Domestic Partner | Date of Birth | Enroll in Health | Enroll in Dental |
|---|---|---|---|
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |

## DECLARATION

1. We are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for our common welfare.
2. We maintain a common residence and it is our intent to continue to do so.
3. We agree to financially support each other by being jointly responsible for each other's necessities, including without limitation, food, clothing, housing, and medical care.
4. We are not legally married to, legally separated from, or are in a Domestic Partnership with anyone else.
5. We are at least eighteen (18) years of age or older and are mentally competent to consent to a contract.
6. We are not related by blood closer than would bar marriage in our state of residence.
7. We understand that willful falsification of information herein may lead to disciplinary action, loss of benefits coverage, and/or the recovery of the cost of benefits received related to such falsification.
8. We understand that any person, employer, or company who suffers any loss because of false statements contained in this Declaration may bring civil action against either or both of us to recover their losses, including reasonable attorney fees.
9. We understand that this Declaration may have legal implications which may need competent legal and accounting advice.

## CERTIFICATION OF DOMESTIC PARTNER AS A DEPENDENT

Please check one:

☐ **Yes**, my Domestic Partner qualifies as my dependent for federal income tax purposes as defined in Internal Revenue Code sec. 152. I understand that on the basis of the above statements, the state will consider the above person my dependent for income tax purposes.

☐ **No**, my Domestic Partner does not qualify as my dependent for federal income tax purposes. I understand that I cannot submit claims for FSA health or dependent care expenses of my Domestic Partner or my Domestic Partner's child.

## AFFIRMATION

We affirm that the statements in this Declaration are true to the best of our knowledge. We have read and understand the instructions provided to us with this Declaration. We acknowledge that this form is not an application for insurance coverage and that the purpose for this form is to establish the eligibility of dependents named above for coverage, as provided under the state's Employee Benefits Program. I understand that falsely certifying dependency status may result in adverse tax consequences and potential charges of tax fraud. I further agree to notify the State of Iowa immediately of any change in this tax status.

**Employee Signature:**_____ **Date:**_____

**Domestic Partner Signature:** _____ **Date:**_____

# Fact Sheet Domestic Partnership in Health and Dental Insurance

## Domestic Partner Benefits

- Domestic Partner benefits are not provided to all employees.
- The employee, the Domestic Partner, and his/her eligible children must meet the state's eligibility benefit requirements.
- Information in this declaration is only used by the state for the sole purpose of determining eligibility for Domestic Partner Benefits.

### Declaration of Domestic Partnership

- The Declaration of Domestic Partnership form is only Valid through the end of the calendar year in which it is signed.
- All employees covering a Domestic Partner need to complete a new Open Enrollment Declaration of Domestic Partnership form during the state's Open Enrollment period every calendar year.

### Change in Domestic Partnership

- When an employee enrolls the Domestic Partner and his/her eligible children in health and/or dental coverage, the elections remain in effect through the end of the calendar year.
- The employee cannot make any changes until the next Open Enrollment period unless he/she experiences a qualified life event and the benefit change requested is consistent with the event.

### Termination of Domestic Partnership

- If the Domestic Partner relationship is terminated, the employee must notify their Human Resources Contacts (HRA) in writing within thirty (30) days of the termination.
- The employee will complete the appropriate forms to cancel the Domestic Partner and his/her eligible children from health and/or dental coverage.
- Health and dental coverage will terminate at the end of the month the HRA receives the necessary signed form.
- Any Added Value Tax will be removed the first of the following month after the notification in writing. For more information, please visit the Tax Treatment of Health and Dental Insurance website.

### COBRA

- The former Domestic Partner and his/her dependents will not be eligible for COBRA and will not be notified of termination. COBRA will not be offered to a Domestic Partner or his/her children if the employee terminates employment, or if the Domestic Partner's dependents have an event that makes them ineligible for the state's health and dental plans.

### Employee and Domestic Partner Are State Employees

- If both the employee and the designated Domestic Partner are both state employees and are both eligible for health and dental insurance, the state's Duplicate Coverage policy will apply.

**Employee Signature:** _____ **Date:** _____

**Domestic Partner Signature:** _____ **Date:** _____