IOWA
Department of Administrative Services

Declaration of Domestic Partnership

Employee First Name, Middle Initial, Last Name: _____

Date of Birth: _____ Last Four Digits of Social Security Number: _____

Complete the following if adding eligible dependents of the domestic partner.

Dependent Name: _____ Date of Birth: _____
- ☐ Enroll in Health
- ☐ Enroll in Dental

Dependent Name: _____ Date of Birth: _____
- ☐ Enroll in Health
- ☐ Enroll in Dental

Dependent Name: _____ Date of Birth: _____
- ☐ Enroll in Health
- ☐ Enroll in Dental

Dependent Name: _____ Date of Birth: _____
- ☐ Enroll in Health
- ☐ Enroll in Dental

Dependent Name: _____ 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 know that this form is not an application for insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under the State's Employee Benefits Program.

Employee Signature: _____ Signature Date: _____

Domestic Partner Signature: _____ Signature Date: _____

Indicate if the Domestic Partner is also a State employee by providing the department name below:

State Agency: _____

Please submit completed form to your Human Resources Associate

Domestic Partner Information

Retain this information for your records

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 Partnership benefits.

Declaration of Domestic Partnership

The declaration is only effective during the calendar year in which it is signed. All employees covering a domestic partner need to complete a new Declaration of Domestic Partnership 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 from health and dental coverage, the elections remain in effect to 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 Associate (HRA) 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 dental coverage. Health and dental coverage will terminate at the end of the month the HRA receives the necessary signed form.

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.

Resources

DAS Domestic Partner Benefits website
DAS Duplicate Coverage website
Tax Treatment of Health and Dental Insurance website
Agency Human Resources Contacts website