Domestic Partnership
Reenrollment in Health and Dental Insurance

I have experienced the following life event that permits adding family members to my health and dental coverage.

Qualifying Life Event _____

Event Date _____

- I want to reenroll my domestic partner and his/her child(ren) in the State's health and/or dental insurance plans.
- I am making this change within 30 days after the date of the event.
- I currently have an Affidavit of Domestic Partnership on file.

I understand that enrollment is subject to all of the State of Iowa Group Insurance Plan rules and regulations. Further, I understand that I will not be able to cancel their coverage until the next annual Enrollment and Change period unless there is a qualifying event that would allow for cancellation.

Domestic partner and his/her child(ren)	Date of Birth	Enroll in Health	Enroll in Dental
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Tax Consequences

I hereby certify that my domestic partner and domestic partner's children whom I am enrolling for health and /or dental insurance coverage:

☐ Qualify as dependents under IRC Section 152 (as modified by 105(b))

☐ Do Not Qualify as dependents under IRC Section 152 (as modified by 105(b))
Please note that if your domestic partner and child(ren) ***do not*** *qualify as dependents under IRC Section 152 (as modified by 105(b)), you will pay federal, state, and FICA taxes on the amount (the added value) that provides coverage to your domestic partner and his/her child(ren).*

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 Name (Printed): _____ Last Four Digits of Your SSN: _____

Employee Signature: _____

Signature Date: _____

Please submit completed form to your Human Resources Associate