Marion County
Declaration of Domestic Partner Tax-Dependent Status

SECTION 1

Employee Name: _____ SSN# _____

Division/Department: _____ Work Phone: _____

SECTION 11

I, _____, certify that:
(Employee Name)

My domestic partner, _____, is also my dependent.
(Name of Domestic Partner)

In relationship to this dependent status, I affirm that my domestic partner and I meet each of the conditions described below.

1. We share the same principal place of residence; and
2. I provide more than one-half of my domestic partner's support.

SECTION III

1. I understand that this Declaration of Domestic Partner Tax-Dependent Status (Declaration) shall be terminated by a change in circumstances attested to in this Declaration.
2. I agree to notify Employee Benefits within thirty-one (31) calendar days if there is any change of circumstances attested to in this Declaration by submitting a Statement of Termination of Dependent Status.

SECTION IV

I understand that the information in this Declaration will be used by Marion County for the sole purpose of determining the tax treatment of benefits provided to my domestic partner and that any other use of the information will be subject to disclosure only upon my express written authorization or if otherwise required by law.

I understand that signing this Declaration may have legal implications beyond the extension of insurance coverage for which it is intended.

I understand that it is my responsibility to provide Marion County with documents establishing that the above-named domestic partner is my tax-qualified dependent, if Marion County requests such documentation. If I do not produce documentation with thirty-one (31) calendar days of the request, Marion County may elect to retroactively rescind the tax-qualified status of my domestic partner's coverage and I may be taxed on the fair market value of the health insurance coverage provided by Marion County for my domestic partner.

I understand that Marion County, or any other company, is found to owe taxes or incurs other damages because of a false statement contained in this Declaration, Marion County or company may bring a civil action against me to recover their losses, including reasonable attorney's fees.

I understand that inclusion of false or misleading information in the Declaration may lead to disciplinary action up to and including discharge from employment, and I attest that the certification I have provided herein in true and correct.

_____ _____
Employee's Signature Date

_____ _____
Witness Signature Date

_____ _____
Employee Benefits Staff Signature Date