



Certification of Tax-Qualified Dependents of Domestic Partnership

Employee Information: _____
(Employee Name: Last, First, Middle) (Date of Birth)

(Social Security Number)

Domestic Partner Information: _____
(Domestic Partner Name: Last, First, Middle) (Date of Birth)

(Social Security Number)

Domestic Partner Certification as an IRS Tax-Qualified Dependent

I certify that the previously named person whom I am enrolling for coverage is my legal tax dependent under IRS Section 152(a) and the Income Tax Regulations issued thereunder. I agree to notify City of Springfield immediately of any change in this status. This Certification applies to the entire calendar year (January 01 – December 31) in which the Certification is signed and subsequent calendar years (January 1 – December 31) unless specifically stated herein or until the City is notified of any change in this tax status.

(Employee Signature) (Date)

Children of the Domestic Partner Information

(List only children of the Domestic Partner who are IRS-defined dependents of the employee for federal income tax purposes. Do not include children of the Employee.)

<u>Child's Name (Last, First, Middle)</u>	<u>Social Security Number</u>	<u>Date of Birth</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dependent Child Certification as an IRS Tax-Qualified Dependent

I certify that the previously named dependent children whom I am enrolling for coverage is/are my legal tax dependent(s) under IRS Section 152(a) and the Income Tax Regulations issued thereunder. I agree to notify City of Springfield immediately of any change in this tax status. This Certification applies to the entire calendar year (January 1 – December 31) in which the Certification is signed and subsequent calendar years (January 1 – December 31) unless specifically stated herein or until the City is notified of any change in this tax status.

(Employee Signature) (Date)

Declination of Tax-Qualified Dependent Status (Domestic Partner only)

At this time I have no tax-qualified dependents on my health plan and I understand that it is my responsibility to notify City of Springfield by completing a new Certification of Tax-Qualified Dependents of Domestic Partnership form if/when this changes.

(Employee Signature) (Date)