



## Qualified Dependent Declaration

### TAXABILITY INFORMATION

Employee Name: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

Same-Sex Spouse's Name: \_\_\_\_\_

I understand that if my same-sex spouse, and/or his/her child(ren), do not qualify as my dependent(s) under Section 152 of the Internal Revenue Code, **the cost of providing coverage for them will be considered taxable income to me and subject to federal tax withholding. In addition, I understand that if I terminate employment with the State and/or lose coverage under this plan, or if my dependents lose coverage because our relationship ends, my dependent(s) would not be eligible for COBRA Continuation Coverage.**

The same-sex spouse identified above: **IS**  **IS NOT**  a qualified IRS dependent under IRC Section 152.  
(Please check one)

### ENROLLMENT OF CHILDREN OF A SAME-SEX MARRIAGE

<u>Name of Child(ren)</u>	<u>Birth Date</u>	<u>Soc. Sec. #</u>	<u>IRS Dependent Of Employee?</u>
1. _____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. _____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. _____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

### SIGNATURE

We hereby certify that the foregoing is true and correct. We acknowledge that false statements could result in disciplinary action, up to and including dismissal, and/or result in violation of federal law.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Signature of Same-Sex Spouse

**\*\* PLEASE NOTE \*\***

*This form MUST accompany the Medical/Dental Enrollment form. Failure to do so may delay the effective date of coverage. Please call 802-828-3455 with questions.*