



**DOMESTIC PARTNERSHIP  
Tax Dependent Status Form**

**I. INSTRUCTIONS**

Before you enroll your domestic partner and/or domestic partner's child(ren) for medical or dental coverage, be prepared to indicate whether your domestic partner and/or his or her child(ren) are your tax dependent(s) for federal income tax purposes. Use this form to indicate whether or not your domestic partner qualifies as your tax "dependent" under the Internal Revenue Code. Because the Human Resources Department cannot provide tax advice, seek help from a professional advisor if you have questions.

**II. TAX DEPENDENT STATUS**

If your domestic partner and/or his or her child(ren) qualify as your tax dependent(s) as that term is defined by the Internal Revenue Code (IRC) and its regulations, then you may pay for your portion of medical and dental premiums with before tax dollars. Furthermore, the additional portion of the premiums the City of Austin pays will be provided tax-free. Finally, you may also be able to be reimbursed from your FLEXTRA Health Care or Dependent Care Accounts for their health and/or dependent care expenses.

If your domestic partner and/or your domestic partner's child(ren) do not qualify as your tax dependent(s) for federal income tax purposes, then you must pay for your portion of medical and dental premiums with after tax dollars. Furthermore, the additional portion of the premiums the City of Austin pays for the coverage of your domestic partner and/or his or her child(ren) will be included (i.e., imputed) in your gross income and subject to applicable payroll taxes. Finally, you will not be able to be reimbursed from your FLEXTRA Health Care or Dependent Care Accounts for their health and/or dependent care expenses.

If you fail to indicate the federal income tax status of your domestic partner and/or your domestic partner's children below, the City of Austin will treat your domestic partner and/or domestic partner's children as not qualifying as your tax dependent's for federal income tax purposes.

**III. TAX STATUS SELECTION**

Indicate below whether or not your domestic partner qualifies as your "dependent" for federal income tax purposes, as that term is modified for purposes of coverage under accident or health plans under Internal Revenue Code section 105(b).

**You should consult with a qualified attorney or financial advisor before you verify that your domestic partner and/or your domestic partner's child(ren) are dependents as defined by IRC Section 152, without regard to the amount of their annual gross income.**

**Domestic Partner Tax Dependent Status**

**Check the box that applies.**

Is your domestic partner your “dependent” as that term is defined by the Internal Revenue Code and its regulations and as that term is modified for purposes of coverage under accident or health plans under Internal Revenue Code section 105(b)?

**Yes**

**No**

**Children of the Domestic Partner Tax Dependent Status**

**Check the box that applies.**

Are the children of your domestic partner who you intend to cover your “dependents” as that term is defined by the Internal Revenue Code and its regulations and as that term is modified for purposes of coverage under accident or health plans under Internal Revenue Code section 105(b).

**Yes**

**No**

**IV. SIGNATURE**

I understand that the declarations I have made herein have legal and financial implications and that, before signing this document, I should seek competent professional legal and/or tax advice. I agree to reimburse the City of Austin for any and all liability including, but not limited to, taxes, penalties, or losses, that the City of Austin may incur due to its reliance on the statements I have made on this form. I will notify the Plan Administrator in writing, within thirty-one (31) days, if there is any change in my domestic partner status which may make my domestic partner no longer eligible for benefits or if there is any change in the partner’s “dependent” status for federal income tax purposes.

\_\_\_\_\_  
Employee/Retiree Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee/Retiree Social Security Number