QUALIFIED DOMESTIC PARTNERSHIP INFORMATION SHEET

FOR CITY OF PHOENIX BENEFITS ELIGIBLE EMPLOYEES AND RETIREES

Benefits eligible employees and retirees may apply for qualified domestic partner coverage for same gender or opposite gender domestic partners who meet the eligibility criteria below. Please note: If you are legally married to someone of the same sex or the opposite sex, you may enroll your spouse without going through this process. The qualified domestic partner's eligible children may be covered, also. When approved,

- Medical, dental, Buy-up Vision and optional life insurance coverage is made available to the **employee's** qualified domestic partner and eligible children.
- Medical, dental coverage is made available to the **retiree's** qualified domestic partner and eligible children.

Eligibility for coverage must be established and approved before enrollment occurs. *It is the employee's or retiree's* ***responsibility to read this information sheet*** *and* ***provide all information*** *needed to establish a domestic partner as being qualified for City benefits coverage.* ***This includes completing and submitting the Affidavit, Change Form, Dependent Status Form and requested documentation.***

ELIGIBILITY

The City of phoenix defines a Qualified Domestic Partner as a person of the same or opposite gender who is not legally married and:

1. Shares your permanent residence; ***and h***as resided with you continuously for at least the past 12 consecutive months and is expected to continue to reside with you indefinitely; ***and***
2. Both individuals have been financially interdependent for at least the past 12 months in at least two ways such as:
    a. Holding one or more credit or bank accounts jointly, such as a checking account in both names;
    b. Owning or leasing your permanent residence as joint tenants;
    c. Reciprocally naming each other as a life insurance beneficiary or in a will;
    d. Each agreeing in writing to assume financial responsibility for the welfare of the other (i.e., durable power of attorney);
    e. Both names on the same insurance policy, i.e. auto;
    f. Both names listed on any utility bill; ***and***

Two forms of documentation are required to establish financial interdependence

3. Has not signed a declaration of Affidavit of Qualified Domestic Partnership with anyone else within the last 12 months; ***and***
4. Both parties are at least 18 years old and mentally competent to consent to a contract when this Qualified Domestic Partnership begins; ***and***
5. Is not a blood relative any closer than would prohibit legal marriage; ***and***
6. Is not acting under fraud or duress.

NOTE: If you are recently divorced and wish to add your ex-spouse as a QDP, you must wait 12 months before you can apply for QDP coverage.

Tax Implications

Domestic partners are not recognized by the IRS (refer to the Defense of Marriage Act or DOMA for details).

SINGLE Coverage to FAMILY Coverage
If adding a Qualified Domestic Partner changes your coverage **from** single **to** family, the difference between what the City pays for single coverage and family coverage must be treated as imputed income. This premium amount will also be deducted from your paychecks on an **after-tax** basis. IRS regulations requires that imputed income is added to your gross taxable income and may increase the amount of tax you pay.

FAMILY Coverage is in Effect Before Adding a Qualified Domestic Partner
You will not have imputed income implications if you already have family coverage when you add a Qualified Domestic Partner to your coverage. If you currently are enrolled in family coverage, there will be no change to your premiums.

Your Responsibilities

The employee or retiree must notify the Benefits Office at (602) 262-4777 of any changes that affect the qualified domestic partner's eligibility within 31 days. This includes marriage to each other, which makes the spouse eligible for coverage as a legally married spouse with no imputed tax implications.

When children are covered, birth certificates and other pertinent documentation **is** required to establish eligibility for coverage. In the event of marriage and continued benefits coverage, a copy of the marriage certificate is required to establish eligibility for coverage. If the employee or retiree does not provide documentation as requested, coverage for dependents will end or be denied.

If you do not remove an ineligible dependent within 31 days, you are financially responsible for the claim costs the dependent incurred while they were ineligible. These claim costs include the amount paid to any hospital, lab, doctor's office, pharmacy, dentist or orthodontist.

The City self-insures its medical and dental coverage and repayment for these claims is directed to the City's Health Care Benefits Trust. Repayment is made by check or payroll deduction.

To Apply

You may apply for Qualified Domestic Partner coverage during the annual **Open Enrollment** that occurs each Fall or **within 31 days** of meeting all requirements. If, during Open Enrollment, you wish to add your QDP **AND** make a medical carrier change, you **MUST** make the Open Enrollment change online through eCHRIS **first**, and then submit QDP paperwork. (The Benefit election process by the employee is a separate process from QDP.) You and the Qualified Domestic Partner must complete and provide a notarized **Affidavit** to the City Benefits Office. You must also agree to notify the City's Benefits Office within 31 days if the domestic partnership terminates or if you marry.

The employee can elect up to $50,000 of Optional LIfe Insurance for the Qualified Domestic Partner without Evidence of Insurability. If an employee wants to elect Optional Life Insurance for their QDP, the election must be indicated on the City of Phoenix Qualified Domestic Partner (QDP) Enrollment Form. If an employee wants to elect an Optional Life Insurance amount over $50,000 for their Qualified Domestic Partner you must submit Evidence of Insurability (EOI) to Minnesota Life Insurance Company within 31 days of QDP application approval. Optional Life Insurance is not available to retirees.

- Your QDP must be present if you elected QDP coverage that requires Evidence of Insurability (an electronic signature is needed)
- An email address is needed
- The process takes 10-30 minutes to complete
- You will not be able to save your work and return later. Set aside sufficient time to complete the process in one sitting
- Have your medical information available, specifically the name/address of physicians, hospitals and clinics where you've been treated and details regarding diagnosis and treatment.

Visit **LifeBenefits.com/SubmitEOI**

1. Provide your group policy number: **34390**
2. Enter your access key: **Phoenix**
3. Complete the word validation

Proof of eligibility for qualified domestic partner coverage may be required by the Benefits Office at any time. The Benefits Office reserves the right to determine eligibility and the effective date(s) of coverage.

- Qualified Domestic Partners of active employees enrolled in the Legal Insurance Plan may also use this service.
- Keep in mind the Flexible Spending Account (FSA) **cannot** be used to cover your Qualified Domestic Partner's or their children's health or dependent care expenses.
- Please contact the Retirement Office at 602-534-4400 for further information on naming your Qualified Domestic Partner as a beneficiary for retirement plan purposes.

RE-ENROLLMENT OF A QUALIFIED DOMESTIC PARTNER

When you remove your Qualified Domestic Partner from coverage for any reason, you may be required to go through the application process again if you wish to re-enroll them in the future.

SAVERS CHOICE HEALTH PLAN

If you enroll a Qualified Domestic Partner in the Savers Choice Health Plan with Health Savings Account, expenses incurred by your Qualified Domestic Partner are not eligible for Health Savings Account reimbursement per IRS Code.

TERMINATION OF COVERAGE

To terminate these benefits due to dissolution of the partnership or failure to meet any stated requirement, **A Statement of Qualified Domestic Partnership Termination** must be submitted to the Benefits Office within 31 days of the event. You are strongly encouraged to provide a copy to the former partner.

The effective date of termination for Medical, Dental, Buy-up Vision and Optional Life Insurance coverage due to the termination of a Qualified Domestic Partnership will be the last day of the month in which the termination occurs.

Former Qualified Domestic Partners and their dependent children are eligible to continue existing medical and dental coverage under the *Consolidated Omnibus Budget Reconciliation Act (COBRA)* of 1986 upon the Employee/Retiree's termination of the Qualified Domestic Partnership.

When terminating your (active employee) Qualified Domestic Partnership, your deductions for medical, dental and Buy-up Vision will be taken on a pre-tax basis beginning the first of the month following the Life Status Change if the change is made within 31 days. If the Status Change is not completed within 31 days, your pre-tax deduction will begin the first of the month following notice to the Benefits Office.

Please note that your application for Qualified Domestic Partnership cannot be evaluated until all documents are submitted and the application is complete. The evaluation process may take up to two weeks. You will be notified via email or mail of the determination.

Don't forget to include the following when submitting your application for QDP!

- Completed, signed and notarized Affidavit
- Completed and signed Enrollment/Change Form (include copies of birth certificates, etc. when adding children)
- Completed Certification of Eligibility and Dependent Status for Health Coverage
- Two pieces of required documentation showing financial inter-dependence
- Mail to Human Resources/Benefits, 251 W. Washington, Phoenix, 85003 or email to benefits.questions@phoenix.gov

Please ensure that all documentation is legible and complete including phone numbers, social security numbers, dates of birth, etc.

City of Phoenix

Affidavit of Qualified Domestic Partnership

Name of Employee/Retiree:______________________________________ Emp I.D. # _________________

Current Employee ______ New Hire_______

Name of Domestic Partner:_______________________________________

Current Address:____ Daytime Phone:_____________

____ Cell: ______________________

City, State, Zip Code Email: ______________________

Qualifying Event : Newly Eligible _____ Loss of Group Coverage _____ Open Enrollment ______

The undersigned Employee/Retiree and Domestic Partner, being of sound mind, having been duly sworn (or making affirmation) under law, hereby state the following:

1. That the undersigned share a single permanent residence and have done so continuously for at least the past 12 consecutive months **and;**

2. That the undersigned have been financially interdependent for at least the past 12 months in at least two of the following ways:

    a. Holding one or more credit or bank accounts jointly, such as a checking account in both names. **Attach a copy of a redacted bank statement or blank voided check with both names printed on the check.**
    b. Owning or leasing your permanent residence as joint tenants. **Attach a copy of your deed or lease.**
    c. Naming your partner as a beneficiary of your life insurance or your will **and** being named by your partner as a beneficiary of their life insurance or their will. **Attach copies of beneficiary record and/or will.**
    d. Each agreeing in writing to assume financial responsibility for the welfare of the other such as a durable financial power of attorney. **Attach a copy of documents.**
    e. Both names on the same insurance policy. **Attach a copy of insurance policy showing names.**
    f. Both names listed on utility bill, i.e., auto. **Attach a copy of bill.**

3. That neither the undersigned has executed or filed a declaration or Affidavit of Qualified Domestic Partnership with another person in the last 12 months; and

4. That the undersigned are at least 18 years of age and are under no legal disability that would prevent them from making this Affidavit; and

5. That the undersigned are not married to anyone, or each other, at this time; and

6. That the undersigned are not related by blood in any degree that would prevent their marriage.

READ AND SIGN BELOW

The Employee/Retiree and Domestic Partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. The Employee/Retiree and Domestic Partner understand that these statements are given for the purpose of establishing their eligibility under one or more policies of insurance issued to the City of Phoenix and understand that any misrepresentation, whether or not made with the intent to deceive, will result in the ineligibility of the Domestic Partner for *Qualified Domestic Partnership* coverage under such policy or policies, voiding of such coverage, and disciplinary action by the City including, but not limited to, termination of employment. The Employee/Retiree and Domestic partner agree to furnish, upon the city's request, evidence to substantiate any statement made herein, and that the City may require the Employee/Retiree and/or Domestic Partner, to reaffirm all statements made herein periodically or when a claim is submitted.

Joint residence was ***first established*** on this date ____

____ ____________________________

Employee or Retiree Signature *Date*

____ ____________________________

Domestic Partner Signature *Date*

Notary

State of Arizona

County of Maricopa

On this ______________ day of ______________________, 20_______, before me, a Notary Public, came the above-named ____ and ____, whose identifies were known or satisfactorily proven to me, who being duly sworn according to law, executed the above Affidavit for the purposes recited therein, stating that the representations made therein are true and correct to the best of their knowledge, information and belief.

____

Notary Public

My Commission expires: ________________________________

THIS MUST BE COMPLETED!

City of Phoenix Qualified Domestic Partner (QDP) Enrollment Form

If you are legally married to someone of the same sex or the opposite sex, you may enroll your spouse in coverage without going through this process. Use this form to reflect any change you wish to make to your optional life, medical, Buy-up Vision and/or dental coverage(s). Fill in **all** information completely and accurately. Your change must be consistent with the event. **When a family status change occurs, you have 31 days from the event to make any necessary change to your benefits. If you are dropping a dependent, this must occur within 31 days to avoid financial responsibility for claims. If you are adding a dependent, you must do so within 31 days or wait until the next Open Enrollment period.** Call the Benefits Office at (602) 262-4777 with questions. Contact the Benefits Office immediately if you have waited more than 31 days to remove a dependent.

OPTIONAL LIFE INSURANCE COVERAGE

Applicant:	*Coverage Amount Requested:*
*Employee:	$
*Qualified Domestic Partner	$
Child(ren):	$

*Optional life insurance can be requested for your QDP within 31 days of receiving confirmation that your QDP application has been approved. Coverage may be subject to underwriting.

Please review important information on the next page.

MEDICAL AND/OR DENTAL COVERAGE

Is a parent, spouse/qualified domestic partner, or child employed by the City of Phoenix?

Yes ☐ No ☐ If yes, Name: ______________________ Empl ID# : ____________

MEDICAL:		DENTAL:		VISION:	
☐ **Banner/ Aetna HMO**	☐ **Single**	☐ **CIGNA HMO**	☐ **Single**	☐ **BUY-UP VISION**	☐ **Single**
☐ **BCBS PPO**	☐ **Family**	☐ **CIGNA PPO**	☐ **Family**		☐ **Family**
☐ **BCBS Savers Choice**	☐ **Waive**	☐ **PPO PLUS**	☐ **Waive**		☐ **Waive**

In the box below **indicate changes only (add or drop)** to your medical, Buy-up Vision and/or dental (MED/DEN/VIS) coverage(s).
The Benefits Office will require supporting documentation.

ADD/ DROP	Med	Den	Vis	LAST NAME	FIRST NAME	RELATION	SSN	DOB	SEX

Reason/Event: ☐ **Newly Eligible** ☐ **New Hire** ☐ **Loss of Group Coverage** ☐ **Open Enrollment**

Effective Date:

CERTIFICATION AND DEDUCTION AUTHORIZATION

I certify that the above statements are true to the best of my knowledge. I understand that omissions or misstatements may be cause for rejection of claims, denial of benefits, and disciplinary action by the City, including but not limited to termination of employment. I authorize the required payroll deduction(s), where applicable, and understand that the deduction(s) will remain in effect unless I report a change in family status in a timely manner or make a change during SelectCare® open enrollment period. I understand that non-payment of premium results in cancellation of coverage. I accept and acknowledge that any monies due to the City of Phoenix, including but not limited to unpaid premium, claim overpayment, including LTD overpayment, and related health care expenses may also be deducted from my pay as deemed necessary to reimburse the City of Phoenix and/or its insurance carrier.

Print Employee Name ______________________ **Empl ID#** ______________

Employee Signature ______________________ **Date** ______________

Contact phone/email ______________________

BENEFITS USE ONLY

OPT EE ______ to ______ Medical Option Code ______ to ______ Entered by ______________

OPT SP/QDP ______ to ______ Dental Option Code ______ to ______

OPT DC ______ to ______ PEHP Option Code ______ to ______ Date ______________

Vision Option Code ______ to ______

	Month	Medical EE	Medical ER	Dental EE	Dental ER	PEHP
Bill						
Refund						

Optional Life Insurance

For Employee

If you never enrolled in Optional Life Insurance, you can enroll in $10,000 or $20,000 of Optional Life Insurance with no questions asked. If you want more than $20,000, you are required to complete a health history questionnaire to be reviewed by Minnesota Life Insurance.

If you are already enrolled, but wish to increase that amount, you may increase your Optional Life Insurance amount by $10,000 or $20,000 without Evidence of Insurability as long as the total amount of the employee's Optional Life Insurance doesn't exceed $150,000. You can apply to increase your Optional Life Insurance by $30,000 or more, or a level greater than $150,000 by completing Evidence of Insurability. Maximum amount that you may request is $500,000 ($50,000 increments from $250,000 - $500,000).

Minnesota Life Insurance has the right to ask for additional medical information before making a decision about your application for additional coverage.

Go to *phoenix.gov/benefits* for instructions on how to complete the Evidence of Insurability online and for Optional Life Insurance rates.

For Spouse/Qualified Domestic Partner

Spouse and Qualified Domestic Partner coverage is available in $10,000 increments up to $300,000. For the first 31 days after hire, newly eligible for benefits, marriage or QDP application approval, the employee can elect up to $50,000 of spouse/QDP coverage with no underwriting requirement.

For Dependent Children

The child coverage provides blanket coverage for all eligible children in your family at one affordable rate for up to $25,000 of coverage per child. Children are covered to age 26 when they meet the City's definition of an eligible child.

City of Phoenix
Certification of Eligibility and Dependent Status for Health Coverage

The City of Phoenix Healthcare Benefit Trust ("Trust") offers medical, dental and vision coverage for employees, qualified domestic partners, and children. In order to ensure that the City is providing appropriate tax treatment, we must confirm whether the individuals you have enrolled for coverage meet the definition of a "dependent" under federal law. The Internal Revenue Service (IRS) provides information to help determine a dependent's tax status on the IRS website at irs.gov. If you have additional questions about whether your dependent is considered a tax dependent, please consult with a tax advisor.

I, ______________________, understand that the City has a need to confirm that my qualified domestic partner, and/or child(ren) meet the definition of "dependent" for tax purposes while enrolled in the City's Health Plans.

I declare that the individuals listed below, whom I wish to enroll for coverage under the Health Plan, qualify as my qualified domestic partner, or child(ren) as defined in the Health Plan and are therefore eligible for coverage under the Health Plans.

I further certify that any individual for whom I have checked the box labeled "Yes" under Tax Dependent as defined in Internal Revenue Code Section 7703 and that each individual for whom I have checked the box labeled "Yes" under Tax Dependent is my tax dependent as defined in Internal Revenue Code Section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B)).

Employee:

____ ____________________
Name Social Security Number

Qualified Domestic Partner: **Tax Dependent**

________________________________ ________________ ☐ Yes ☐ No
Name Social Security Number

Child(ren): **Tax Dependent**

________________________________ ________________ ☐ Yes ☐ No
Name Social Security Number

________________________________ ________________ ☐ Yes ☐ No
Name Social Security Number

________________________________ ________________ ☐ Yes ☐ No
Name Social Security Number

________________________________ ________________ ☐ Yes ☐ No
Name Social Security Number

By signing below, you are stating that:

I certify that the information I have listed above is true. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I understand if any of the information I have provided is false or misleading, it could result in disciplinary and possible disenrollment from the program(s). I agree to notify the Benefits Office within thirty-one (31) days of any change by email:

benefits.questions@phoenix.gov

or if by mail at:

Attn: Benefits Division (7th Floor)
251 West Washington Street Phoenix, Arizona 85003

And I will include in the notice an updated **Certification of Eligibility and Dependent Status**. I am aware that changes may impact my dependent's eligibility for coverage, as well as the tax consequences of that coverage. I further agree that if there is any tax liability associated with my failure to provide accurate information or timely notice upon change in dependent status, that I am responsible for any and all damages I may suffer, including without limitation the cost of any tax filings, including amended returns, tax advice and any penalties and additional tax associated with failure to provide accurate and timely information.

______________________________ ______________________________
Printed Name of Employee **Signature of Employee**

____
Employee Identification Number

____
Date

Acceptance by Plan

______________________________ ______________________________
Signature of Plan Representative **Date**

____
Printed Name