

## AFFIDAVIT OF TAX DEPENDENCY FOR HEALTH COVERAGE

Use this Affidavit of Tax Dependency for Health Coverage ("Affidavit") if you would like to cover your domestic partner as a tax dependent for health coverage purposes under the College's Benefit Plan ("Plan").

Generally, if you cover your domestic partner under the Plan, the cost of such coverage is paid on an after-tax basis. However, coverage can be paid on a pre-tax basis if your domestic partner qualifies as a tax dependent for health coverage purposes. You should sign this Affidavit only if your domestic partner meets the entire list of requirements set.

You must complete this Affidavit in the presence of a notary public and send the completed Affidavit and supporting documentation to the Office of Human Resources, Benefit's Office. Upon receipt, the College will review the Affidavit and documentation before making its determination, and then either confirm eligibility for the tax treatment for the health coverage of your domestic partner or notify you if any further information is required.

Please keep a copy of all materials presented for your own records.

Name of College Employee: \_\_\_\_\_ PID: \_\_\_\_\_

Name of Domestic Partner: \_\_\_\_\_

I certify that we have demonstrated our evidence of domestic partnership for the Plan and still meet the criteria as outlined in the College's Benefit Plan SPD and the original affidavit signed when coverage for my domestic partner began. I understand that my domestic partner will not qualify as a tax dependent for health coverage purposes unless they have already met the eligibility requirements of a domestic partner and your domestic partner relies on you for more than half of the household support, you can pay for his or her coverage on a pre-tax basis. **In order to meet the household support test, your income must be more than 50% of your total household income as of the date you complete your elections.** If this changes at any time, you must notify the Benefit's Office.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

STATE OF FLORIDA  
COUNTY OF \_\_\_\_\_

The above named person has sworn to and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, and is personally known to me or has produced \_\_\_\_\_ as identification.

\_\_\_\_\_  
Notary Public

Commission Expires: \_\_\_\_\_