

## **DEFINITION OF DOMESTIC PARTNER BENEFITS**

Baltimore County Public Schools (BCPS) offers same and opposite sex domestic partners and their dependents the opportunity to enroll in the BCPS Flexible Benefits Plan. Benefits provided to an employee/retiree's domestic partner or the partner's eligible children are equivalent to those available for an employee/retiree's spouse or spouse's eligible dependents. This coverage is available to qualified domestic partners of both active and retired employees.

*All forms must be received by the Benefits Office within thirty (30) days of filing a domestic partnership affidavit with all required supporting evidence; for active employees, if not received within thirty (30) days, you will have to wait until the next enrollment period to add your domestic partner and your partner's eligible dependents, to be effective the next plan year.*

### **WHAT ARE THE REQUIREMENTS FOR DOMESTIC PARTNERSHIP?**

To establish a domestic partnership, you and your partner must *either*,

1) satisfy all of the following requirements:

- share a close personal relationship and be responsible for each other's welfare;
- have shared the same legal residence for at least twelve (12) months;
- be at least 18 years old;
- have voluntarily consented to the relationship, without fraud or duress;
- not be married to, or in a domestic partnership with, any other person;
- not be related by blood or affinity in a way that would disqualify them from marriage under State law;
- be legally competent to contract; and,
- share sufficient financial and legal obligations (described below in the section on *Required Evidence*).

*or*,

2) legally register the domestic partnership, if:

- a domestic partnership registration system exists in the jurisdiction where the employee resides.

### **WHAT EVIDENCE IS REQUIRED FOR DOMESTIC PARTNERSHIP?**

You must provide the following:

1) the attached *Affidavit For Domestic Partnership* signed in the presence of a notary public by both the employee/retiree and the employee/retiree's partner under penalty of perjury declaring that they satisfy the requirements of a domestic partnership;

*and*,

2) evidence that you and your partner share items described in at least two (2) of the following (*this requirement does not apply to a qualified, registered domestic partnership*):

- a joint housing lease, mortgage, or deed;
- joint ownership of a motor vehicle;
- a joint checking or credit account;
- designation of the partner as a primary beneficiary of the employee's life insurance, retirement benefits, or residuary estate under a will; or,
- designation of the partner as holding a durable power of attorney for health care decisions regarding the employee.

**UNDER WHICH GROUP INSURANCE PLANS MAY I ENROLL MY DOMESTIC PARTNER AND MY PARTNER'S ELIGIBLE DEPENDENTS?**

Active and retired employees may enroll your domestic partner and your partner's eligible dependents in your medical plan, your dental plan, and your vision plan. Qualified dependents of active employees only are also eligible to participate in the Optional Life insurance plan and the Optional Personal Accident insurance plan. **Please note that, under current tax law, reimbursements cannot be made from your Health Care Spending Account for expenses incurred by your domestic partner or your partner's eligible dependents, if they are not your legal tax dependents. The same is true for the Dependent Care Spending Account (in addition to other qualifying requirements that apply).**

**WHO QUALIFIES AS AN "ELIGIBLE DEPENDENT" OF MY DOMESTIC PARTNER FOR GROUP INSURANCE PURPOSES?**

The following dependents of your domestic partner are eligible dependents for group insurance purposes:

- the unmarried children of your domestic partner, residing with you, under age 19 years of age or up to age 25 if a full-time student in an accredited school or college;
- the unmarried child of your domestic partner over the age limit if:
  - they are dependent on you for primary financial support and maintenance due to a physical or mental disability, they are incapable of self-support, and the disability existed before reaching age 19 or while covered under the plan.
- Eligible children include your:
  - Natural children
  - Stepchildren
  - Legally adopted children
  - Foster children
  - A child for whom you have legal guardianship including grandchildren
  - Child for whom the court has issued a QMSCO (Qualified Medical Child Support Order)

**HOW DO I ENROLL MY DOMESTIC PARTNER AND MY PARTNER'S ELIGIBLE DEPENDENTS IN MY GROUP INSURANCE PLANS?**

To enroll your domestic partner and your partner's eligible dependents:

- file a notarized *Affidavit For Domestic Partnership*, with all required supporting evidence with the Benefits Office (*affidavit form is attached*);

- within thirty (30) days of filing the affidavit with all required supporting evidence,
  - complete a benefit enrollment form, if you are changing your level of coverage due to the addition of your domestic partner and your partner's eligible dependents;
  - please note that proof of eligibility, such as a birth certificate, is required to add your partner's eligible dependents to your group insurance plans.

*All forms must be received by the Benefits Office within thirty (30) days of filing a domestic partnership affidavit with all required supporting evidence; for active employees, if not received within thirty (30) days, you will have to wait until the next enrollment period to add your domestic partner and your partner's eligible dependents, to be effective the next plan year.*

**HOW DOES THE ADDITION OF MY DOMESTIC PARTNER AND MY PARTNER'S ELIGIBLE DEPENDENTS TO MY GROUP INSURANCE PLAN AFFECT MY TAX SITUATION?**

Internal Revenue Service regulations require different tax treatment for group insurance costs associated with domestic partner coverage in cases where the partner does not qualify as a tax dependent under the IRS Code (in determining the tax effect of domestic partner coverage, the Board will assume that neither your domestic partner or your partner's eligible dependents qualify as tax dependents, unless you are able to provide documentation to the contrary).

*For active employees who pay their portion of the group insurance costs with pre-tax payroll deductions, the addition of a domestic partner and the partner's eligible dependents to those group insurance plans will have the following effects:*

**Payroll Deduction for active employees**

For each group insurance plan to which you add your domestic partner and your partner's eligible dependents –

- you will pay the difference between your cost for single coverage and your cost for the coverage level that includes the addition of your domestic partner and your partner's eligible dependents, with after-tax deductions; if you are already above the single coverage level because you cover a tax-qualified dependent, then the portion of that difference described above, to be paid with after-tax deductions will be adjusted to reflect proportion that your domestic partner and your partner's eligible dependents bear to the total number of dependents you cover;
- the amount remaining between your total cost (which includes the addition of your domestic partner and your partners eligible dependents) and the what is paid with after-tax deductions (as determined above), will be paid with pre-tax deductions.

*Examples:*

- 1)
  - you currently have single coverage, the cost of which = \$30 bi-weekly;

- after adding your domestic partner and your partner's two children, your coverage level increases to family and your cost = \$81;
- the difference between your cost for single coverage and your cost for family coverage =  $\$81 - \$30$  or \$51;
- the after-tax portion of your total deduction of \$81 for family coverage = \$51;
- the pre-tax portion of your total deduction of \$81 for family coverage =  $\$81 - \$51$  or \$30.

2)

- you currently have family coverage, that includes your two children, the cost of which = \$81 bi-weekly;
- your cost, if you had single coverage = \$30;
- after adding your domestic partner and your partner's two children, your coverage level remains as family and your cost remains = \$81;
- the difference between your cost for single coverage and your cost for family coverage =  $\$81 - \$30$  or \$51;
- the proportion of dependents covered via the domestic partnership to the total dependents you cover, including those covered via the domestic partnership =  $\frac{3}{5}$  or 60%;
- the after-tax portion of your total deduction of \$81 for family coverage =  $60\% \times \$51$  or \$30.60;
- the pre-tax portion of your total deduction of \$81 for family coverage =  $\$81 - \$30.60$  or \$50.40.

### **Imputed Income for active and retired employees**

If you cover dependents who do not qualify as tax dependents under the IRS Code, the value of the Board's contribution toward that coverage is considered wages, subject to tax withholding. This is known as *imputed income*. The way that imputed income is determined is very similar to the way that your after-tax deduction is determined, except that the amount the *Board* pays is substituted for the amount *you* pay.

*Examples:*

1)

- you currently have single coverage, for which the Board pays = \$271 bi-weekly;
- after adding your domestic partner and your partner's two children, your coverage level increases to family and the Board now pays = \$730;
- the difference between the Board's cost for single coverage and the Board's cost for family coverage =  $\$730 - \$271$  or \$459;
- you will have reportable imputed income = \$459, subject to tax withholding from your paycheck.

2)

- you currently have family coverage, that includes your two children, for which the Board pays = \$730;
- if you had single coverage, the Board would pay = \$271;

- after adding your domestic partner and your partner's two children, your coverage level remains as family and the Board's cost remains = \$730;
- the difference between the Board's cost for single coverage and the Board's cost for family coverage = \$730 - \$271 or \$459;
- the proportion of dependents covered via the domestic partnership to the total dependents you will cover, including those covered via the domestic partnership =  $\frac{3}{5}$  or 60%;
- you will have reportable imputed income =  $\$459 \times 60\%$  or \$275.40, subject to tax withholding from your paycheck.

***For active and retired employees who pay their portion of the group insurance costs with after-tax deductions from their paycheck or retirement check, or through direct bill, the addition of a domestic partner and the partner's eligible dependents to those group insurance plans will have only the imputed income effect described above.***

### **WHAT IF MY DOMESTIC PARTNERSHIP ENDS?**

Should your relationship with your domestic partner end, or you no longer meet the domestic partnership requirements, the domestic partner and the partner's eligible dependents are no longer eligible for coverage under Baltimore County Public School's group insurance and retirement plans. You must notify the Benefits Office within thirty (30) days of the termination event. In such case, benefits will terminate or continue for the domestic partner and the partner's eligible dependents as they would for a former spouse under similar circumstances (such as a divorce). For example, the domestic partner and the partner's eligible dependents may be able to continue their health coverage under COBRA.

### ***PLEASE NOTE:***

The information presented in this material has been prepared to assist you in understanding the provisions of domestic partner benefits. While this material attempts to summarize the provisions of domestic partner benefits and answer questions you may have, it is by no means exhaustive or exclusive. NO GUARANTEE OR CONTRACT IS CREATED BY THIS MATERIAL. In the event that this material conflicts with federal law or collective bargaining agreements in effect, the language of the federal law and the collective bargaining agreements will be the final authority.

**Retiree Domestic Partner Coverage  
Monthly Taxable Imputed Income  
Effective 1/1/2012 - 12/31/2012**

**A. Imputed Income Member and Partner are both under 65**

|                                                   | 30 or more Years of Service |              |                   | 20-29 Years of Service |              |                   | 10-19 Years of Service |              |                   |
|---------------------------------------------------|-----------------------------|--------------|-------------------|------------------------|--------------|-------------------|------------------------|--------------|-------------------|
|                                                   | Child of Partner only       | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child |
| CareFirst BlueCross BlueShield Triple Choice/MPOS | \$550.67                    | \$778.00     | \$948.70          | \$458.89               | \$648.33     | \$790.59          | \$305.93               | \$432.22     | \$527.06          |
| CIGNA OAPIN (In Network)                          | \$416.17                    | \$587.98     | \$716.99          | \$346.81               | \$489.98     | \$597.49          | \$231.21               | \$326.65     | \$398.33          |
| CIGNA OAP (In/Out Network)                        | \$469.83                    | \$663.77     | \$809.41          | \$391.53               | \$553.14     | \$674.51          | \$261.02               | \$368.76     | \$449.67          |
| Kaiser Permanente HMO                             | \$483.48                    | \$683.10     | \$832.98          | \$402.90               | \$569.24     | \$694.15          | \$268.60               | \$379.49     | \$462.77          |

**B. Imputed Income Member and Partner are both over age 65**

|                                     | 30 or more Years of Service |              |                   | 20-29 Years of Service |              |                   | 10-19 Years of Service |              |                   |
|-------------------------------------|-----------------------------|--------------|-------------------|------------------------|--------------|-------------------|------------------------|--------------|-------------------|
|                                     | Child of Partner only       | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child |
| CIGNA Medicare Surround             | \$523.78                    | \$441.48     | \$965.26          | \$411.54               | \$346.88     | \$758.42          | \$224.47               | \$189.20     | \$413.68          |
| Kaiser Permanente HMO Medicare Plus | \$547.50                    | \$309.65     | \$857.15          | \$547.50               | \$309.65     | \$857.15          | \$372.30               | \$210.56     | \$582.86          |

**C. Imputed Income if Member is Over Age 65 and Domestic Partner is Under Age 65**

|                                                   | 30 or more Years of Service |              |                   | 20-29 Years of Service |              |                   | 10-19 Years of Service |              |                   |
|---------------------------------------------------|-----------------------------|--------------|-------------------|------------------------|--------------|-------------------|------------------------|--------------|-------------------|
|                                                   | Child of Partner only       | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child |
| CareFirst BlueCross BlueShield Triple Choice/MPOS | \$561.20                    | \$561.20     | \$1,111.86        | \$467.66               | \$467.66     | \$926.55          | \$311.77               | \$311.78     | \$617.70          |
| CIGNA OAPIN (In Network)                          | \$424.12                    | \$424.12     | \$840.30          | \$353.43               | \$353.43     | \$700.25          | \$235.62               | \$235.62     | \$466.83          |
| CIGNA OAP (In/Out Network)                        | \$478.81                    | \$478.81     | \$948.63          | \$399.00               | \$399.00     | \$790.53          | \$266.00               | \$266.00     | \$527.02          |
| Kaiser Permanente HMO                             | \$492.75                    | \$492.75     | \$976.23          | \$410.62               | \$410.62     | \$813.52          | \$273.75               | \$273.75     | \$542.35          |

**D. Imputed Income if Member is Under Age 65 and Domestic Partner is Over 65**

|                                     | 30 or more Years of Service |              |                   | 20-29 Years of Service |              |                   | 10-19 Years of Service |              |                   |
|-------------------------------------|-----------------------------|--------------|-------------------|------------------------|--------------|-------------------|------------------------|--------------|-------------------|
|                                     | Child of Partner only       | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child |
| CIGNA Medicare Surround             | \$561.20                    | \$441.48     | \$1,002.68        | \$467.66               | \$346.88     | \$814.54          | \$311.77               | \$189.20     | \$500.97          |
| Kaiser Permanente HMO Medicare Plus | \$492.75                    | \$309.65     | \$802.40          | \$410.62               | \$309.65     | \$720.27          | \$273.75               | \$210.56     | \$484.31          |

\* Dental and Vision coverage have no imputed income.

**Retiree Domestic Partner Coverage  
Monthly Taxable Imputed Income  
Effective 1/1/2011 - 12/31/2011**

**A. Imputed Income Member and Partner are both under 65**

|                                                   | 30 or more Years of Service |              |                   | 20-29 Years of Service |              |                   | 10-19 Years of Service |              |                   |
|---------------------------------------------------|-----------------------------|--------------|-------------------|------------------------|--------------|-------------------|------------------------|--------------|-------------------|
|                                                   | Child of Partner only       | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child |
| CareFirst BlueCross BlueShield Triple Choice/MPOS | \$520.73                    | \$735.69     | \$897.12          | \$433.94               | \$613.08     | \$747.60          | \$289.29               | \$408.72     | \$498.40          |
| CIGNA OAPIN (In Network)                          | \$435.78                    | \$615.69     | \$750.77          | \$363.15               | \$513.06     | \$625.64          | \$242.10               | \$342.04     | \$417.09          |
| CIGNA OAP (In/Out Network)                        | \$462.88                    | \$653.96     | \$797.45          | \$385.74               | \$544.97     | \$664.54          | \$257.16               | \$363.31     | \$443.03          |
| Kaiser Permanente HMO                             | \$401.00                    | \$601.51     | \$891.11          | \$334.17               | \$501.25     | \$742.59          | \$222.78               | \$334.17     | \$495.06          |

**B. Imputed Income Member and Partner are both over age 65**

|                                     | 30 or more Years of Service |              |                   | 20-29 Years of Service |              |                   | 10-19 Years of Service |              |                   |
|-------------------------------------|-----------------------------|--------------|-------------------|------------------------|--------------|-------------------|------------------------|--------------|-------------------|
|                                     | Child of Partner only       | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child |
| CIGNA Medicare Surround             | \$495.30                    | \$415.64     | \$910.94          | \$389.16               | \$326.57     | \$715.74          | \$212.27               | \$178.13     | \$390.40          |
| Kaiser Permanente HMO Medicare Plus | \$495.06                    | \$307.65     | \$802.71          | \$495.06               | \$307.65     | \$802.71          | \$336.64               | \$209.20     | \$545.84          |

**C. Imputed Income if Member is Over Age 65 and Domestic Partner is Under Age 65**

|                                                   | 30 or more Years of Service |              |                   | 20-29 Years of Service |              |                   | 10-19 Years of Service |              |                   |
|---------------------------------------------------|-----------------------------|--------------|-------------------|------------------------|--------------|-------------------|------------------------|--------------|-------------------|
|                                                   | Child of Partner only       | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child |
| CareFirst BlueCross BlueShield Triple Choice/MPOS | \$530.69                    | \$530.69     | \$1,051.41        | \$442.23               | \$442.23     | \$876.18          | \$294.82               | \$294.83     | \$584.12          |
| CIGNA OAPIN (In Network)                          | \$444.11                    | \$444.11     | \$879.89          | \$370.09               | \$370.09     | \$733.24          | \$246.73               | \$246.73     | \$488.83          |
| CIGNA OAP (In/Out Network)                        | \$471.73                    | \$471.73     | \$934.61          | \$393.10               | \$393.10     | \$778.84          | \$262.07               | \$262.07     | \$519.23          |
| Kaiser Permanente HMO                             | \$445.55                    | \$445.55     | \$846.55          | \$371.29               | \$371.29     | \$705.46          | \$247.53               | \$247.53     | \$470.31          |

**D. Imputed Income if Member is Under Age 65 and Domestic Partner is Over 65**

|                                     | 30 or more Years of Service |              |                   | 20-29 Years of Service |              |                   | 10-19 Years of Service |              |                   |
|-------------------------------------|-----------------------------|--------------|-------------------|------------------------|--------------|-------------------|------------------------|--------------|-------------------|
|                                     | Child of Partner only       | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child | Child of Partner only  | Partner only | Partner and child |
| CIGNA Medicare Surround             | \$530.69                    | \$415.64     | \$946.33          | \$442.23               | \$326.57     | \$768.80          | \$294.82               | \$178.13     | \$472.95          |
| Kaiser Permanente HMO Medicare Plus | \$445.55                    | \$307.65     | \$753.20          | \$371.29               | \$307.65     | \$678.94          | \$247.53               | \$209.20     | \$456.73          |

\* Dental and Vision coverage have no imputed income.

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**BALTIMORE COUNTY PUBLIC SCHOOLS  
AFFIDAVIT FOR DOMESTIC PARTNERSHIP**

*(ALL REQUIRED EVIDENCE AND DOCUMENTATION MUST BE ATTACHED TO THIS FORM)*

**Part I – DECLARATION, DOMESTIC PARTNER CRITERIA, & DOCUMENTATION**

I, \_\_\_\_\_, Social Security # \_\_\_\_\_,  
*Employee/Retiree - Print Name*

and I, \_\_\_\_\_, Social Security # \_\_\_\_\_,  
*Domestic Partner - Print Name*

affirm, under penalty of perjury, that we are domestic partners as defined under the Baltimore County Public Schools Definition of Domestic Partner Benefits in that either –

(1) We satisfy **all** the following requirements:

- (A) share a close personal relationship and be responsible for each other's welfare;
- (B) have shared the same legal residence for at least twelve (12) months;
- (C) be at least 18 years old;
- (D) have voluntarily consented to the relationship, without fraud or duress;
- (E) not be married to, or in a domestic partnership with, any other person;
- (F) not be related by blood or affinity in a way that would disqualify them from marriage under State law;
- (G) be legally competent to contract; and
- (H) share sufficient financial and legal obligations to satisfy at least two of the following items **(evidence required)**:
  - 1. a joint housing lease, mortgage, or deed;
  - 2. joint ownership of a motor vehicle;
  - 3. a joint checking or credit account;
  - 4. designation of the partner as a primary beneficiary of the employee's life insurance, retirement benefits, or residuary estate under a will; or,
  - 5. designation of the partner as holding a durable power of attorney for health care decisions regarding the employee.

or,

(2) The jurisdiction in which we reside has a domestic partner registration system and we have legally registered the domestic partnership in that jurisdiction.

**Part II - Termination of domestic partnership.**

(1) We understand that we must notify the Benefits Office within 30 days after:

- (A) Termination of the domestic partnership by death or dissolution; or,
  - (B) Any other change in circumstances that disqualifies the relationship as a domestic partnership.
- (2) We further understand that when the domestic partnership ends, benefits will terminate or continue in the same manner and to the same extent that the Board terminates or continues, respectively, benefits for a former spouse in equivalent circumstances (such as dissolution of a partnership and divorce).

**Part III – TAX CONSEQUENCES OF DOMESTIC PARTNER AS A DEPENDENT**

- (1) We understand this information will be held confidential and will be subject to disclosure only upon our express written authorization or if otherwise required by law.
- (2) We understand that declaration of domestic partnership and of responsibility for our common welfare may have legal and tax implications under federal and Maryland law. We understand that if an employee/retiree receives health benefits, including medical, dental, vision and prescription, for a domestic partner, and if that domestic partner is not a dependent of the employee/retiree under the Internal Revenue Code, that employee/retiree will be required to pay taxes on the value of the benefit. We understand that we are encouraged to contact a tax advisor or an attorney regarding tax implications of domestic partner benefits.
- (3) We understand that enrollment in benefits to which I or my dependents (including a domestic partner) are not entitled is considered fraud. I further understand that if I willfully misrepresent the eligibility of myself or my dependents (including a domestic partner), or fail to take the necessary action to remove ineligible dependents (including a domestic partner), or in any way obtain benefits to which I am not entitled, my benefits will be canceled, I may be required to repay any claims which have been paid inappropriately, and I may face charges or dismissal from Board service.

\_\_\_\_\_  
Employee/Retiree's Signature

\_\_\_\_\_  
Date

Subscribed and sworn to before me this \_\_\_\_\_ day of, \_\_\_\_\_ 20\_\_.

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

My commission expires \_\_\_\_\_

\_\_\_\_\_  
Domestic Partner's Signature

\_\_\_\_\_  
Date

Subscribed and sworn to before me this \_\_\_\_\_ day of, \_\_\_\_\_ 20\_\_.

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

My commission expires \_\_\_\_\_

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**BALTIMORE COUNTY PUBLIC SCHOOLS  
STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP**

This statement is intended for the sole purpose of determining eligibility for domestic partnership benefits at Baltimore County Public Schools, referred to here as the Board.

When this statement is received in the Office of Employee Benefits & Retirement of the Board, benefits will be discontinued on the last day of the month that the statement is received, or on a date consistent with existing policies and procedures.

I, (employee/retiree name) \_\_\_\_\_, certify that the following is accurate:

1. (name of domestic partner) \_\_\_\_\_  
and I are no longer domestic partners as defined in the Affidavit of Domestic Partnership filed by me with the Board on (date) \_\_\_\_\_.

2. I am filing this Statement of Termination in order to cancel the abovementioned Affidavit of Domestic Partnership.

3. I am mailing my former partner a copy of this notice at:

(former partner's address) \_\_\_\_\_

\_\_\_\_\_  
(date mailed) \_\_\_\_\_

I declare that the above statements are true and correct.

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

INTERNAL USE ONLY:

\_\_\_\_\_  
Benefits Office Acceptance

\_\_\_\_\_  
Date

## **SUMMARY OF TAX TREATMENT OF HEALTH COVERAGE PROVIDED FOR DOMESTIC PARTNERS**

### **Domestic Partners Eligible for Health Coverage**

Group health coverage is available under BCPS's health plan for domestic partners (and their children, if applicable) of BCPS's eligible employees. Refer to the applicable summary plan description (SPD) and enrollment materials for a definition of domestic partner and the procedures you must follow to enroll your domestic partner (and his or her children, if applicable) for coverage.

### **Tax Consequences of Domestic Partner Coverage of Active Employees**

Under federal tax law, if your (non-spouse) domestic partner does not qualify as your dependent for health coverage purposes (as defined below), then you will be unable to pay for your domestic partner's coverage (and his or her children's coverage, if applicable) on a pre-tax basis under the cafeteria plan. The value of your domestic partner's coverage, less the amount you pay for it on an after-tax basis, will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported on your Form W-2. This includes any portion of the premiums that the Board of Education pays for your domestic partner's health coverage. Further, you may not use your health flexible spending account (if any) to pay for the unreimbursed medical expenses of your domestic partner (and his or her children, if applicable).

If your domestic partner qualifies as your dependent for health coverage purposes, then you will be able to pay for your domestic partner's coverage (and his or her children's coverage, if applicable) on a pre-tax basis under the cafeteria plan. Additionally, no portion of the premiums paid by the Board of Education will be included in your income or be subject to federal withholding or employment taxes. Further, you may use your health flexible spending account to pay for the unreimbursed medical expenses of your domestic partner (and his or her children, if applicable).

Note that if your domestic partner (and his or her children, if applicable) fail to qualify as your dependent(s) for health coverage purposes for the entire year because of a change of abode, household, or support during the year, the value of your domestic partner's coverage for the portion of the year prior to the change will be included in your gross income and related income tax and employment tax withholding will be charged to your pay as rapidly as possible. The catch-up on withholding may reduce your take-home pay for some periods.

### **Tax Consequences of Domestic Partner Coverage of Retired Employees**

Under federal tax law, if your (non-spouse) domestic partner does not qualify as your dependent for health coverage purposes (as defined below), then the portion of the premium for your domestic partner's coverage (and his or her children's coverage, if applicable) paid for by the Board of Education, will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported on your Form W-2.

If your domestic partner qualifies as your dependent for health coverage purposes, then no portion of the premiums paid by the Board of Education will be included in your income or be subject to federal withholding or employment taxes. Note that if your domestic partner (and his or her children, if applicable) fail to qualify as your dependent(s) for health coverage purposes for the

entire year because of a change of abode, household, or support during the year, the value of your domestic partner's coverage for the portion of the year prior to the change will be included in your gross income and you will be invoiced for the related income tax and employment tax.

### **Who Is a Dependent for Health Coverage Purposes?**

The following conditions must be met in order for your domestic partner to qualify as your dependent for health coverage purposes under federal tax law:

- You and your domestic partner have the same principal place of abode for the entire calendar year;
- Your domestic partner is a member of your household for the entire calendar year (the relationship must not violate local law);
- During the calendar year you provide more than half of your domestic partner's total support;
- Your domestic partner is not your (or anyone else's) "qualifying child" under Code § 152(c); and
- Your domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.

Your domestic partner could be your dependent for health coverage purposes even if you do not claim an exemption for him or her on your IRS Form 1040.

To determine whether you provide more than half of your domestic partner's total support, you must compare the amount of support you provide with the amount of support your domestic partner receives from all sources, including Social Security, welfare payments, the support you provide, and the support your domestic partner provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and the like. If you believe you might provide more than half of your domestic partner's support, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information) before you complete the Recertification Statement described below.

The rules above should also be applied to determine if your domestic partner's children qualify as your dependents for health coverage purposes.

### **Filing a Recertification Statement**

If your domestic partner (and his or her children, if applicable) qualify as your dependent(s) for health coverage purposes, you can avoid having the value of their health coverage treated as taxable income. Because the determination of whether a person is a dependent for health coverage purposes turns on facts solely within your knowledge, BCPS cannot make this determination for you. It can be complex to determine whether an individual satisfies the definition of a dependent for health coverage purposes under the Internal Revenue Code. You may wish to consult a tax professional for advice on your personal situation before you declare that your domestic partner and his or her children, if applicable, are eligible for tax-favored health coverage. This document does not constitute tax advice.

To avoid taxation, you must complete and return the attached Recertification Statement, indicating that your domestic partner (and his or her children, if applicable) qualify as your dependent(s) for health coverage purposes. You will be asked to complete a Recertification Statement each year. For any year in which BCPS does not receive a Recertification Statement from you, BCPS will assume that your domestic partner (and his or her children, if applicable) does not qualify as your dependent(s) for health coverage purposes for that year.

## RECERTIFICATION STATEMENT

I hereby certify that the statements below are true and correct.

1. \_\_\_\_\_ is my domestic partner as of the date of this Recertification.
2. I have read the notice entitled "Summary of Tax Treatment of Health Coverage Provided for Domestic Partners," and understand the requirements for qualifying another person as my dependent for health plan purposes.
3. I have listed my domestic partner and each of his or her children that I have enrolled for under the BCPS health plan and indicated whether I declare them to be eligible for federally tax-favored health coverage.

| <b>Name(s)</b> | <b>Tax Dependent</b>                                           |
|----------------|----------------------------------------------------------------|
|                | <b><u>Cal. Year 20</u></b>                                     |
| Partner _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Child _____    | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Child _____    | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Child _____    | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Child _____    | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |

Please note that this Recertification Statement is not an enrollment form. Please contact the Office of Employee Benefits, as necessary, for the appropriate forms to enroll or terminate the coverage of any of the individuals listed above.

4. I agree to notify the Plan Administrator of the BCPS's group health plan in writing within 30 days if there is any change in the above person(s)'s status as my tax dependent(s) for health coverage purposes, including any change that may occur mid-year. I understand that any change in such status may result in the retroactive application of taxes to amounts previously paid for health coverage during the year.
5. I understand that on the basis of the above statements, BCPS will decide whether to treat the above person(s) as my dependent(s) for health coverage purposes, and that if I fail to complete this Recertification Statement, then BCPS will assume that the person(s) do not qualify as my dependent(s) for health coverage purposes and that the coverage will be subject to all applicable federal, state, local, and payroll taxes.
6. I understand that if the above person(s) do not qualify as my dependent(s) for health coverage purposes, I cannot use my health flexible spending account (if any) to pay for their unreimbursed medical expenses (for active employees only)
7. I agree to reimburse BCPS for any and all taxes, penalties, or other losses (including reasonable attorneys' fees) that BCPS may incur as a result of its reliance on this Recertification Statement if it is untrue or incorrect in any respect, or if I fail to provide the notice required by paragraph 4 above.

Date: \_\_\_\_\_ By: \_\_\_\_\_  
(Signature of Employee/Retiree)

\_\_\_\_\_  
(Please Print Name)

**Form W-4**

Department of the Treasury  
IRS

**Form MW 507**

State of Maryland  
Comptroller's Office

**EMPLOYEE'S COMBINED WITHHOLDING  
ALLOWANCE/EXEMPTION CERTIFICATE**

Dear Employee:

Below is a combined IRS Form W-4 and Maryland Form MW507. The information on this form tells us:

- how many withholding allowances or exemptions you are claiming. For each allowance/exemption claimed, you reduce the amount of wages subject to income tax withholding.
- your marital tax status.
- if you are claiming that you are exempt from income tax withholding.
- if you are certifying that you are a nonresident in Maryland.

This information is used to determine how much federal and state income tax to withhold from your wages.

All newly hired employees must provide their employer with a completed and signed form on or before their first day of work. Otherwise, your employer must withhold taxes as if the employee were single with zero withholding allowances/exemptions (this will result in the maximum amount of tax being withheld).

Employees may file a new form whenever the number of allowances/exemptions they are entitled to increases or they think that they are entitled to claim exempt from withholding (this claim must be renewed each February). Employees **MUST** file a new form within 10 days of a **DECREASE** in the number of withholding allowances/exemptions claimed.

Employees are responsible for making sure that their federal and state income tax withholding is correct.

The IRS and Maryland Comptroller's Office provide additional instructions and worksheets to assist employees in completing the form. You may obtain a copy of these instructions and worksheets by accessing [www.irs.gov](http://www.irs.gov) and [www.comp.state.md.us](http://www.comp.state.md.us).

Please complete the form below and send it to the Office of Payroll, Timonium.

**Employee's Combined Withholding Allowance Certificate**  
BCPS must send a copy of this form to the IRS if: (a) you claim more than 10 allowances  
or (b) you claim "Exempt" and your wages are normally more than \$200 per week.

|                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                       |  |                                                                                                                                                                            |           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| <b>1</b> Type or print your first name and middle initial                                                                                                                                                                                                                                                                                                              |  | Last name                                                                                                                                                                                                                                             |  | <b>2</b> Your social security number                                                                                                                                       |           |
| Home address (number and street or rural route)                                                                                                                                                                                                                                                                                                                        |  | <b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate.<br>Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |  |                                                                                                                                                                            |           |
| City or town, state, and Zip code                                                                                                                                                                                                                                                                                                                                      |  | Cnty of residence or Balt. City                                                                                                                                                                                                                       |  | <b>4</b> Check box <input type="checkbox"/> if your last name differs from that shown on your social security card.<br><b>You must call 1.800.772.1213 for a new card.</b> |           |
|                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                       |  | Federal                                                                                                                                                                    | MD        |
| <b>5</b> Total number of allowances/exemptions you are claiming . You may claim fewer than you are entitled to, or zero.....                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                       |  | <b>5</b>                                                                                                                                                                   |           |
| <b>6</b> Additional amount, if any, you want withheld from each paycheck.....                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                       |  | <b>6</b>                                                                                                                                                                   | \$        |
| <b>7</b> I claim exemption from withholding for 20__ __, and I certify that I meet both of the following conditions for exemption:<br>* Last year I had a right to a refund of ALL Federal/MD income tax withheld because I had NO tax liability AND<br>* This year I expect a refund of ALL Federal/MD income tax withheld because I expect to have NO tax liability. |  |                                                                                                                                                                                                                                                       |  | <b>Print</b>                                                                                                                                                               | Federal   |
|                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                       |  | YES/NO?                                                                                                                                                                    | Yes or No |
|                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                       |  | YES/NO?                                                                                                                                                                    | in boxes  |
| If you meet <b>both</b> conditions, write "Exempt" (complete only lines 1, 2, 3, 4, and 7). This must be renewed by February 15 each year.                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                       |  | →                                                                                                                                                                          | <b>7</b>  |

**\* Certification of nonresidence in Maryland. I certify that I am not domiciled in Maryland, and that I do not maintain a place of abode within Maryland. My permanent residence appears above and I am exempt from MD withholding. If so, write "exempt" here. →**

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to exempt status.

**Employee's signature** (Form is not valid unless you sign it.)

|                                                                                                  |  |                               |
|--------------------------------------------------------------------------------------------------|--|-------------------------------|
|                                                                                                  |  | <b>Date</b> →                 |
| <b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to IRS.) |  | <b>9</b> Office               |
|                                                                                                  |  | <b>10</b> Employer ID # (EIN) |

**\*Certification of nonresidence in Maryland**

You may be exempt from Maryland income withholding if you are:

- a) a resident of the District of Columbia, Pennsylvania, Virginia or West Virginia and do not maintain a place of abode within Maryland; and
- b) employed, and commute to work, in Maryland.

**Please note:**

The maintenance of a place of abode in Maryland for more than 6 months of the tax year makes you a statutory resident of Maryland and requires you to file a resident return with Maryland and apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If the status of the employee changes from nonresident to resident during the year, the employee will be subject to Maryland income tax from the date residence was established, and withholding of Maryland income tax will be required of the employer.

Send the completed and signed form to the Office of Payroll, Timonium.