State of New York
Department of Civil Service
Alfred E. Smith State Office Bldg.
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

Application for Domestic Partner Benefits and Affidavit of Domestic Partnership and Financial Interdependence for Active Employees in the following groups: CSEA, UUP, PEF, DC-37, PIA, GSEU, PBA, Judicial Branch employees, M/C, NYSCOPBA (arbitration affected titles) and Legislative employees PS-425.1 (7/06)

The undersigned, being duly sworn, depose and declare as follows:

1. We are both eighteen years of age or older and not married to other individuals. If either or both of us has been married, we submit evidence of the termination of the marriage(s).

2. We are not related by blood in a manner that would bar marriage under the laws of the State of New York.

3. We are each other's sole domestic partner, have been so for at least six months prior to the date of this affidavit, and intend to remain so indefinitely. We are in a relationship of mutual support, caring and commitment, and have assumed responsibility for each other's welfare.

4. We have been living together on a continuous basis for at least six months prior to the date of this affidavit and submit proof of qualifying cohabitation (see reverse side for proof of residency).

5. As domestic partners we are financially interdependent. We submit original documents of two proofs of our financial interdependence (see reverse side for proofs of financial interdependence).

6. One of us is enrolled in the New York State Health Insurance Program (NYSHIP).

7. I, the enrollee, affirm that I have not had a domestic partner enrolled in NYSHIP as my dependent within the last year.

8. I, the enrollee, affirm that I will file a *Termination of Domestic Partnership* form (PS-425.4) within 14 days of the date I/my partner no longer meet one or more of the qualifying criteria set forth above.

9. I, the enrollee, understand that any false or misleading statements made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my partner and potential disciplinary action by my employer.

Print Name (Enrollee)
Social Security No.
Address
Signature *(sign in presence of notary)*

Print Name (Partner)
Social Security No.
Date of Birth
Address
Signature *(sign in presence of notary)*

Sworn to before me _____ this day of _____, _____

_____
NOTARY PUBLIC

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of determining the eligibility of a domestic partner for benefits under the New York State Health Insurance Program, Dental Program, Vision Program, and/ or Employee Benefit Fund Program. The information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Dept. of Civil Service, Alfred E. Smith State Office Building, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375. **For information, related to the Domestic Partnership Program, contact your Agency Health Benefits Administrator. If, after calling your Health Benefits Administrator, you need more information concerning the Domestic Partnership Program, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.**

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YOU NEED A TOTAL OF 3 SEPARATE PROOFS*, AS DESCRIBED BELOW (1 PROOF OF COHABITATION DURATION AND 2 PROOFS OF FINANCIAL INTERDEPENDENCE)

*Proofs should be clearly unaltered copies of original documents.

Proof of Six Months of Cohabitation

You must submit proof that you and your partner have resided together for at least six months. The proof may be one document with both names or two separate documents that show the residence of each partner. The following is a list of items that can be used to demonstrate proof of residency.

Submit one (1) of the following (check proof submitted):

- ☐ Auto registration
- ☐ Bank statement
- ☐ Driver's license
- ☐ Mailed insurance benefits statement
- ☐ Mailed joint membership statement with address (e.g., church or family association)
- ☐ Lease agreement listing both parties
- ☐ Mortgage agreement listing both parties
- ☐ Passport
- ☐ Pay check stub
- ☐ Registration as a domestic partnership in a New York State municipality that has established such a procedure (e.g., Albany, New York City, Rochester, Ithaca)
- ☐ Tax return
- ☐ Telephone bill
- ☐ Utility bill

Proof of Financial Interdependence

You must submit two (2) copies of clearly unaltered original documents as proof of financial interdependence of at least six months duration. Below is a list of acceptable proofs **(at least one of the two items must be from List A). Check the two (2) proofs you are submitting:**

Note: "Joint" proofs must contain both names (enrollee and domestic partner). Original documents will be copied only to the extent necessary to document receipt and returned to you.

LIST A

- ☐ Joint obligation on a loan (including an affidavit by a creditor for a personal loan)
- ☐ Joint ownership of your residence
- ☐ Joint renters' or home owners' insurance policy
- ☐ Joint responsibility for child care (e.g., school documents, guardianship) Birth certificate of child alone is not sufficient.
- ☐ Designated as beneficiary under the other's life insurance policy, retirement benefits account or will or executor of each other's will
- ☐ An affidavit by a corporate creditor or other disinterested third party qualified to testify to partners' financial interdependence
- ☐ Mutually granted durable power of attorney
- ☐ Designation of one partner as the representative payee for the other's government benefits
- ☐ Joint ownership or holding of investments
- ☐ Joint ownership or lease of a motor vehicle
- ☐ Mutually granted authority to make health care decisions (e.g., health care power of attorney)
- ☐ Both listed as tenants on the lease of shared residence
- ☐ Same-sex marriage or civil union certificate
- ☐ Share a household budget for the purpose of receiving government benefits
- ☐ I claim my partner as a dependent for federal tax Purposes (you must complete and submit PS-425.3)

LIST B

- ☐ Joint bank account
- ☐ Joint credit or charge card(s)
- ☐ Status as authorized signatory on the partner's bank account, credit card or charge card
- ☐ Other proof establishing economic interdependence

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EMPLOYEE BENEFITS DIVISION

Instructions for Enrolling Domestic Partners of Active Employees in the following groups: CSEA, UUP, PEF, DC-37, PIA, GSEU, PBA, Judicial Branch employees, M/C, NYSCOPBA (arbitration affected titles) and Legislative employees PS-425 (7/06)

Agreements with the unions representing State employees provide for the extension of coverage to the domestic partners of State employees in the New York State Health Insurance Program (NYSHIP) and the Dental and Vision programs administered by New York State. If you receive dental or vision benefits from an Employee Benefit Fund (CSEA, DC-37 and UUP employees), that fund may also permit you to enroll an eligible domestic partner. These benefits have also been extended to unrepresented employees in the Executive, Legislative and Judicial branches of State government and to State retirees, vestees and dependent survivors. To determine if your domestic partner qualifies for enrollment, carefully read these instructions, which includes important tax information and the Domestic Partner Affidavit (PS-425.1)

The affidavit and documents you are required to submit are only intended to establish the eligibility of your domestic partner for benefits available to you as a New York State employee. However, it is recommended that you seek advice from your attorney regarding any possible legal and financial implications before you take the actions required to provide this coverage to a domestic partner.

Who can be Covered as a Domestic Partner

Enrollees may cover same or opposite sex partners with whom they reside and have a committed, long term relationship of mutual support, and for whom they have assumed long term financial responsibility or have mutual financial responsibility. See the Affidavit of Domestic Partnership and Financial Interdependence (PS-425.1) for details. Persons who live together for economic reasons, but who have not made a commitment to an exclusive enduring domestic partnership as described in these documents, will not be considered to be domestic partners for the purposes of enrollment in New York State administered benefit programs.

How to Enroll a Domestic Partner

1. Complete the following forms:
   - Affidavit of Domestic Partnership and Financial Interdependence (PS-425.1)
   - Health Insurance Transaction Form (PS-404)
2. In addition to the above, **IF** your partner qualifies as your dependent for federal tax purposes and you wish to avoid the additional taxes that may result from this benefit (see Income Tax Implications), you must also complete the Dependent Tax Affidavit (PS-425.3) and return it with the other documents.
3. Return the completed forms and the **REQUIRED PROOFS OF RESIDENCE AND FINANCIAL INTERDEPENDENCE** (see PS-425.1) to your agency Health Benefits Administrator.

Applications filed without the required affidavit or proofs will not be processed. Ambiguity or lack of clarity will not be interpreted in the employee's/partner's favor.

When Coverage Begins

If you are enrolled in NYSHIP, have satisfied the six month residency and financial requirements, and you have submitted all required documentation to your agency Health Benefits Administrator on or before, or within seven days of your partner's first eligibility, the coverage for your partner begins on the date of first eligibility. If you apply more than seven days but less than 29 days after the date of first eligibility, coverage for your partner begins on the first day of the payroll period following the pay period in which you have submitted all required documentation to your agency Heath Benefits Administrator. If you apply 29 days or more after the date of first eligibility, you will be subject to a late enrollment period and coverage for your partner will begin on the first day of the fifth payroll period following the payroll period in which you apply. **Your partner's date of first eligibility is the day that is exactly six months after the latest date of the residency and financial support documents submitted with your application for coverage.**

If you are not enrolled in NYSHIP, coverage for both you and your partner may be deferred until you satisfy the new employee or late enrollment waiting period. Ask your agency Health Benefits Administrator if you must satisfy a waiting period.

Because there is no late enrollment imposed for dental and vision benefits, the effective date of domestic partner coverage would be the date of first eligibility.

When Coverage Ends

Coverage for your partner will end on the day on which you and/or your partner no longer meet one or more of the requirements on the affidavit you both have signed. The terms and conditions of your coverage require you to report this relationship termination within **14 days** of its occurrence.

How to Report that the Partnership has Ended

You must complete and submit the form PS-425.4 "Termination of Domestic Partnership" within **14 days** of the date the partnership ends. The form is available from your agency Health Benefits Administrator. **If you do not file the form on a timely basis, you may be liable for claims paid for your former partner for services rendered on and after the date the partnership ended.** You may not enroll another domestic partner, or re-enroll the same domestic partner, until one year after the date the "Termination of Domestic Partnership" form is filed with your agency Health Benefits Administrator. Your former partner's 60 day eligibility period for applying for COBRA continuation coverage starts on the date the relationship terminates, not the notification date.

Coverage of Domestic Partner's Children

You may provide coverage under State administered benefit programs for you partner's child (children) if the child permanently resides in your household and you provide more than 50% of the child's support. To enroll the child, ask your agency Health Benefits Administrator for form PS-457, "Statement of Dependence". After you complete the form and return it to your agency Health Benefits Administrator, you will be advised whether the child is eligible for coverage. Documentation of the statements made on the PS-457 may be required. Requirements for coverage of your partner's child (children) under union Employee Benefit Funds may differ from those of State administered programs. Consult the appropriate Employee Benefit Fund for its requirements.

Changes of Coverage

Changes of coverage involving domestic partners and their children follow the same rules that dependents follow. If you are enrolled in a pre-tax status, changes to individual medical coverage can only be made during the month of November, unless you have a qualifying event. Changes to dental or vision coverage can be made at any time. Please see your agency Health Benefits Administrator for more details.

INCOME TAX IMPLICATIONS

Imputed Income

Under IRS rules, if a domestic partner is not a "dependent" within the meaning of Section 152 of the Internal Revenue Code (IRC), the "fair market value" of the partner's coverage, less any contribution by the enrollee, is treated as income for federal tax purposes. Check with your agency Health Benefits Administrator for an approximation of the fair market value for State administered health, dental and vision coverage and check with the applicable benefits fund (CSEA, DC-37 and UUP represented employees) regarding the tax status of the benefits provided by them. These values, referred to as "imputed income", will be added to your annual salary for income tax purposes and apply even if you cover other dependents in addition to your partner. If your partner qualifies as a dependent under IRC 152, there is no imputed income. If you qualify under this section, (and ONLY if you qualify) you must complete PS-425.3 Dependent Tax Affidavit and submit it with your other enrollment documents. If your domestic partner's tax status changes during the year, no retroactive changes will be made to imputed income. It is your responsibility to amend your tax return to correct taxable income. If you have questions regarding your eligibility under Section 152, please contact your tax advisor.

Pre-Tax Contribution Program Implications

Under IRC Section 125 rules governing pre-tax contributions, a domestic partner is not an eligible dependent unless they qualify under Section 152. Therefore, if your partner is a covered dependent, the part of the premium you pay for the dependent portion of your health insurance coverage must be deducted on a post-tax basis. The W-2 form issued by the Office of the State Comptroller at the end of the tax year will show only the amount of your premium for the individual portion of your coverage on a pre-tax basis.

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EMPLOYEE BENEFITS DIVISION

DEPENDENT TAX AFFIDAVIT

For Enrolling Domestic Partners of Active Employees
in the New York State Health Insurance Program

PS-425.3 (7/06)

The undersigned, being duly sworn, depose and declare as follows:

My domestic partner, _____

Name Of Domestic Partner and Social Security Number

fully qualifies as my dependent under Internal Revenue Code rule 152. I understand that if my partner's dependent status under IRC 152 changes at any time during the tax year, I will be responsible for reporting and paying tax on any resulting imputed income.

The following are definitions extracted from the Internal Revenue Code that may be helpful in determining if a domestic partner qualifies as a dependent for federal purposes. It is recommended that you seek the advice of an attorney prior to completing this affidavit.

IRC 152 DEPENDENT DEFINED.

(a) GENERAL DEFINITION. - For the purposes of this subtitle, the term "dependent" means any of the following individuals over half of whose support, for the calendar year in which the taxable year of the taxpayer begins, was received from the taxpayer (or is treated under subsection (c) or (e) as received from the taxpayer):

(9) An individual (other than an individual who at any time during the taxable year was the spouse, determined without regard to section 7703, of the taxpayer) who, for the taxable year of the taxpayer, has as his principal place of abode the home of the taxpayer and is a member of the taxpayer's household.

(b) RULES RELATING TO GENERAL DEFINITION. -For purposes of this section-

(5) An individual is not a member of the taxpayer's household if at any time during the taxable year of the taxpayer the relationship between such individual and the taxpayer is in violation of local law.

Print Name (Enrollee)
Social Security No.
Address
Signature *(sign in presence of notary)*

Sworn to before me _____ this day of _____ , _____

_____
NOTARY PUBLIC

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of enabling the NYS Department of Civil Service to process your request to enroll a domestic partner in the New York State Health Insurance Program, Dental Program, Vision Program, and/ or Employee Benefit Fund Program. The information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Department. of Civil Service, Alfred E. Smith State Office Building, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375. **For information, related to the Domestic Partnership Program, contact your Agency Health Benefits Administrator. If, after calling your Health Benefits Administrator, you need more information concerning the Domestic Partnership Program, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.**

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EMPLOYEE BENEFITS DIVISION

Termination of Domestic Partnership for Active Employees in the following groups: CSEA, UUP, PEF, DC-37, PIA, GSEU, PBA, Judicial Branch employees, M/C, NYSCOPBA (arbitration affected titles) and Legislative employees PS-425.4 (7/06)

I, _____ certify that:
Name of Employee (Please Print)

1. I _____ , and _____
Name Of Employee (Please Print) *Name Of Domestic Partner (Please Print)*

have terminated our domestic partnership.

2. I affirm that the effective date of termination of this domestic partnership is: _____
Date

3. I affirm that a copy of this termination statement has been or will be provided to my former domestic partner within fourteen days of termination of this domestic partnership.

4. I understand that another Application for Benefits for a Domestic Partner cannot be filed until one year after this statement of termination of the previous partnership has been filed with my employing Agency's Health Benefits Administrator.

5. I affirm that assertions in this notice are true to the best of my knowledge and understand that false statements or failure to provide timely notification of the termination of the partnership may require payment by myself of claim amounts incorrectly paid on behalf of my former partner listed above. I understand that false statements may result in disciplinary action by my employer or in other legal actions appropriate to the prosecution of insurance fraud.

Signature of Employee:
Date:
Social Security Number:

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of discontinuing coverage provided to a domestic partner under the New York State Health Insurance Program, Dental Program, Vision Program, and/ or Employee Benefit Fund Program. The information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may prevent the Department from processing your request. This information will be maintained by the Director, Division of Employee Benefits, NYS Dept. of Civil Service, Alfred E. Smith State Office Building, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375. **For information, related to the Domestic Partnership Program, contact your Agency Health Benefits Administrator. If, after calling your Health Benefits Administrator, you need more information concerning the Domestic Partnership Program, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.**