DOMESTIC PARTNER – CERTIFICATION OF FEDERAL TAX DEPENDENT STATUS FORM

District of Columbia Employees' Health Benefits Program

If your Domestic Partner or dependent(s) meets the IRS definition of a Tax Dependent, please complete this form and return to the D.C. Department of Human Resources (DCHR). This form must be completed by the first pay period in January of each year during the annual Open Enrollment period or within 30 days of a Qualifying Life Event.

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

1. The following spouse, domestic partner or child(ren) are enrolled for major medical and/or dental coverage and [place your initials next to the one line that applies to you]:

   _____ qualify as my federal tax dependent(s) for health coverage purposes in the current tax year

   OR

   _____ do not qualify as my federal tax dependent(s) for health coverage purposes in the current tax year.

2. I agree to notify DCHR in writing as soon as possible if there is any change in the status of the above person(s) 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.

3. I understand that on the basis of the above statements, DCHR will decide whether to treat the above person(s) as my tax dependent(s) for all federal income and employment tax purposes, and that if I fail to complete this Tax Certification or any recertification requested by DCHR, then DCHR will assume that the above person(s) do not qualify as my federal tax dependent(s) for health coverage purposes.

4. I agree to reimburse DCHR for any and all taxes, penalties, or other losses (including reasonable attorneys' fees) that DCHR may incur as a result of its reliance on this Tax Certification if it is untrue or incorrect in any respect, or if I fail to provide the notice required by paragraph 3 above.

_____

Signature of Employee

_____ _____

Type or Print Name of Employee Date