Overview of Health Coverage For Employees' Domestic Partners

How Does an Employee Qualify for This Benefit?

- If an employee and his or her partner are "domestic partners," they can qualify for medical, dental, or vision benefits by filing a Declaration of Domestic Partnership with the District Plan Administrator or designated representative.

  - "Domestic partners" are defined in the declaration as "two adults of the same-sex who have chosen to share their lives in an intimate and committed relationship, reside together, and share a mutual obligation of support for the basic necessities of life."

  - Specifically, the declaration asks employees seeking this benefit to acknowledge that they and their domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage; are mutually responsible for the cost of basic living expenses; are both at least the minimum age of consent in the state in which they reside; reside together and intend to do so indefinitely; and that neither is married to anyone else.

  - Enrollment of domestic partners and/or child(ren) of domestic partners may only occur during the district's annual enrollment period. The effective date must coincide with the beginning of the district's plan year.

- If an employee chooses to exercise this option, he or she will be able to choose from medical, dental, or vision care plans offered by insurers that have agreed to provide coverage of domestic partners.

- The effective date of coverage may only be on the annual enrollment date for the District that next follows the receipt of the signed Health Care Enrollment Statement and Declaration of Domestic Partnership.

What Happens to the Domestic Partner's Coverage When the Employee Leaves Employment or Dies?

- Coverage is terminated for the Domestic Partner and his or her children. A limited conversion policy may be available from the medical insurer.

What Are the Tax Consequences of Electing This Benefit?

- **THE DISTRICT OR THE SAN DIEGO COUNTY SCHOOLS VOLUNTARY EMPLOYEES BENEFITS ASSOCIATION CANNOT PROVIDE TAX OR LEGAL ADVICE ON THE IMPLICATIONS OF ADDING DOMESTIC PARTNER COVERAGE. INDIVIDUALS SHOULD REVIEW THE IMPLICATIONS WITH THEIR OWN LEGAL OR TAX COUNSEL.**

Information is provided on how some employers are handling this issue, but each district must make its own determination.

- Unless the domestic partner and/or child(ren) of the domestic partner also is considered the employee's dependent for tax purposes under Section 152 of the Internal Revenue Code, the Internal Revenue Service currently treats as imputed income of the employee the value of the health coverage provided domestic partners and their child(ren), if any, less any contribution paid by the employee for this coverage.

- According to the IRS, you are taxed on the fair value of the coverage provided. The cover letter provides the monthly value that the District will use for determining the taxable income for domestic partner coverage in 2003. This is not a guarantee that the IRS will agree with the amount of taxable income. The IRS has never issued regulations on how "fair value" is determined.

Are There Other Legal Consequences To Electing This Benefit?

Employees wishing to opt for this benefit are advised to consult an attorney regarding the possibility that the filing of Domestic Partnership may have other legal consequences, including that it may, in the event of termination of the Domestic Partner relationship, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purpose of establishing and dividing community property, or for ordering payment of support.

Declaration of Domestic Partnership

I, _____, submit this Declaration of Domestic Partnership to
(Name of Employee)

establish _____ as my Domestic Partner (as this term
(Name of Domestic Partner)

is defined below) for the purpose of qualifying for any benefits that the District may extend to employees in a Domestic Partnership.

I, _____, declare and acknowledge as follows:
(Name of Employee)

For Domestic Partner Relationship

I and _____ are Domestic Partners.
(Domestic Partner)

"Domestic Partners" means two adults of the same-sex who have chosen to share their lives in an intimate and committed relationship, reside together, and share a mutual obligation of support for the basic necessities of life.

Specifically, I declare and acknowledge that I and my Domestic Partner named above meet all of the following criteria:

- Are both at least 18 years old
- Share a close personal relationship and are responsible for each other's welfare
- Are each other's sole domestic partner
- Have been in a domestic partner relationship for at least 12 months
- Are not married to anyone and have not had another domestic partner in the past 12 months
- Are not related by blood closely enough to bar marriage in the state of residence
- Share the same regular and permanent residence, with the current intent to continue doing so indefinitely
- Are jointly financially responsible for "basic living expenses," defined as the cost of basic food and shelter, and any other expenses of a domestic partner that the partner bears because of the domestic partnership (equal contributions not required)
- Are mentally competent to consent to the arrangement when the coverage begins.

Declaration of Domestic Partnership

I acknowledge that:

- I cannot file another Declaration of Domestic Partnership for a new Domestic Partnership until at least twelve months after a Statement of Termination of Domestic Partnership has been filed.

- If requested, I will provide to the District's Plan Administrator or designated representative documents establishing the existence of my Domestic Partnership relationship.

- Neither the District nor the San Diego County Schools Voluntary Employees Benefits Association is providing legal advice and that I have been advised to consult an attorney regarding the possible legal implications of filing this Declaration of Domestic Partnership.

- I have an obligation to file a Statement of Disenrollment, Death, or Termination of Domestic Partnership with the District's Plan Administrator or designated representative within thirty (30) days of the earliest of (a) the death of my Domestic Partner; (b) the date on which any of the criteria of a Domestic Partnership relationship is no longer met.

  I further understand that the effective date of the end of the Domestic Partnership relationship is the earliest of (a) the death of my Domestic Partner; (b) the date on which I file a Statement of Disenrollment, Death or Termination of Domestic Partnership with the District's Plan Administrator or designated representative; (c) the date on which the Domestic Partner notifies the Plan of the termination of the Domestic Partnership; (d) the date on which one or more of the criteria of Domestic Partnership are no longer met.

- I understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statement contained in this Declaration of Domestic Partnership, including claims paid under any benefit plans in which I enroll my Domestic Partner and/or child(ren) of a Domestic Partner. The Plan shall have the right to recover attorney fees and costs incurred in collecting such expenses from me.

Declaration of Domestic Partnership

I declare, under penalty of perjury, that the foregoing is true and correct that this Declaration was executed on _____ at _____, California.

DATED:_____

_____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, ZIP Code)

_____
(Signature of Domestic Partner)

_____
(Name of Domestic Partner)

Health Care Enrollment Statement

To enroll _____, and/or his or her eligible dependent
(Name of Domestic Partner)

children, if any, in the District's group health care coverage that, subject to certain limitations, covers District employees and their Domestic Partners, I declare and acknowledge my understanding that:

- The options under the group health coverage currently available to employees who choose to enroll their Domestic Partners and/or child(ren) of Domestic Partners may be more limited than those available to other employees (i.e., limited to medical, dental, and vision coverage only).

- All group health coverage is governed by the terms of the underlying plan(s) ("Plan").

- If I choose to enroll only the child(ren) of my Domestic Partner, I understand that my Domestic Partner may not subsequently enroll in the group coverage until a future District annual enrollment period.

- The effective date of coverage may only coincide with the District's annual health care reenrollment date next following the timely receipt of my signed election.

- Unless my Domestic Partner and/or child(ren) of my Domestic Partner also are considered my dependent for tax purposes under Section 152 of the Internal Revenue Code, the Internal Revenue Service currently treats as imputed income to the employee the value of the health coverage provided the Domestic Partner's dependents, if any, less any contribution paid by the employee for this coverage. I reviewed the examples of imputed income amounts for group health coverage detailed in the cover letter to this Statement.

- I understand that I should consult an attorney concerning the income tax implications of filing this Statement and that neither the District, the San Diego County Schools Voluntary Employees Benefits Association nor any employee or agent can definitely identify the tax consequences.

- I have an obligation to file a statement of Disenrollment, Death or Termination of Domestic Partnership with the District's Plan Administrator or designated representative within thirty (30) days of the earliest of (a) the death of my Domestic Partner, or (b) the date on which any of the criteria of a Domestic Partner relationship is no longer met.

- Regardless of whether the requisite Statement of Disenrollment, Death or Termination of Domestic Partnership has been filed, the effective date of the end of the Domestic Partner relationship, and, therefore, the date on which coverage of my Domestic Partner and his or her dependent children, if any, will end, according to the terms of the Plan, is the earliest of:

— The date on which my Domestic Partner dies;

— The date on which my Domestic Partner and I terminate our Domestic Partnership;

— The date on which one or more of the criteria of Domestic Partnership are no longer met; or

— The date on which I file a Statement of Disenrollment, Death, or Termination of Domestic Partner with the District's Plan Administrator or designated representative.

I affirm that the statements in this Statement are true to the best of my knowledge.

DATED:_____ _____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, ZIP Code)

Statement of Disenrollment, Death Or Termination of Domestic Partnership

I, _____, make and file this Statement of Disenrollment, Death or
(Name of Employee)

Termination of Domestic Partnership in order to cancel the Declaration of Domestic Partnership previously filed.

I wish to cancel, effective immediately, the Declaration of Domestic Partnership previously filed with respect to _____.
(Name of Domestic Partner)

-OR-

The Domestic Partner relationship between me and _____.
(Name of Domestic Partner)

ended on _____.
(Date of Termination)

-OR-

My Domestic Partner, _____, died on _____.
(Name of Domestic Partner) (Date of Death)

For Termination of Group Health Coverage of Domestic Partnership

I understand that, if my Domestic Partner has previously been covered by the District's group health coverage, the effect of filing this Statement of Disenrollment, Death or Termination of Domestic Partnership is that my Domestic Partner, and/or his or her eligible dependent children, if any, will no longer be covered by the District's group health coverage, in accordance with the terms of the underlying plan(s) ("Plan").

I further acknowledge that it is my responsibility to mail a copy of this signed statement to my surviving Domestic Partner, or former Domestic Partner, named above.

I affirm that the statements in this Statement are true to the best of my knowledge.

DATED:_____ _____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, Zip)