

Tulare County
Office of Education

Jim Vidak, County Superintendent of Schools

Tulare County Office of Education Group Health Plan

Affidavit of Dependent Domestic Partner or
Dependent Domestic Partner's Child's Status

I declare under penalty of perjury under the laws of the State of California that the statements below are true and correct.

1. _____ is my domestic partner / domestic partner's child on the date of this Affidavit. *(circle one)*

2. I have read the notice entitled "Summary of Tax Treatment of Benefit Coverage Provided for Domestic Partners," and understand the requirements for qualifying another person as my federal tax dependent.

3. The above person *(place your initials next to the one line that applies to you)*:

_____ qualifies as my federal tax dependent in the current tax year and I expect that he/she will continue to qualify as my federal tax dependent next year and in future tax years.

or

_____ does not qualify as my federal tax dependent in the current tax year, but I expect that he/she will qualify as my federal tax dependent next year and in future tax years.

or

_____ does not qualify as my federal tax dependent in the current tax year, and I do not expect that he/she will qualify as my federal tax dependent next year or in future tax years.

4. I agree to notify the Assistant Superintendent, Human Resources (Plan Administrator of the Tulare County Office of Education Group Health Plan), in writing, as soon as there is any change in the above person's status as my tax dependent.

5. I understand that on the basis of the above statements, the above person will be considered my tax dependent by Tulare County Office of Education (TCOE) for all federal income and employment tax purposes.

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

Dated _____, 200__

Social Security #

Type or Print Name

Signature