

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

**DISABILITY CERTIFICATION FOR DEPENDENT CHILDREN**

**PHYSICIAN'S STATEMENT**

I certify I examined \_\_\_\_\_, birthdate \_\_\_\_\_ and found (him) (her) to be incapable of self-support because of a mental or physical disability which began on \_\_\_\_\_, before (he) (she) reached age 19.  
(approximate date)

In my opinion, the above person:

- Will be incapable of self-support for the duration of (his) (her) life; or
- May become self-supporting if (he) (she) responds to treatment

Approximate date of recovery \_\_\_\_\_.

Physician Name \_\_\_\_\_ Tel. No. \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PARENT'S STATEMENT**

I certify that the above person is my child, is disabled, is dependent on me for support, and is not married.

I hereby request (he) (she) be continued as a family member under my EUTF benefit plans. I agree to submit additional proof of disability as often as required by the EUTF or its insurance carriers. I will notify EUTF of all changes affecting my child's disability or marital status.

I authorize the EUTF and its insurance carriers to use the above information only in compliance with federal and Hawaii laws governing the privacy of health information.

Employee/Retiree Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(Date)

WAIVER

I understand that as a full-time employee of \_\_\_\_\_ I am eligible for group term life under Group policy No(s).\_\_ 881930 \_\_ issued to \_Hawaii Employer-Union Health Benefits Trust Fund\_\_\_\_ by Aetna Life Insurance Company (Aetna). The amount of such insurance is determined in accordance with a schedule contained in the Group Policy(ies).

I further understand that the insurance is provided to all eligible employees at no cost to such employees.

I acknowledge that I have been given the opportunity to enroll for the full amount of term life insurance for which I am eligible under the Group Policy(ies). For personal reasons, I hereby waive on behalf of myself, my heirs and assigns, and the beneficiaries of such insurance, all amounts of insurance for which I am now eligible and for which I may become eligible under the Group Policy(ies) . I also understand that if I wish to reinstate any amount of such insurance at a later date, it must be the full amount for which I am then eligible and I may be required to furnish, at my own expense, evidence of insurability satisfactory to Aetna.

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Policyholder Representative's Name & Title

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Policyholder Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Signed in the presence of

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
ACCEPTANCE BY AETNA

Insurer: Aetna Life Insurance Company  
By: Raymond Welnicki  
Title: Vice President

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

## **EUTF DECLARATION OF DOMESTIC PARTNERSHIP**

### **I. DECLARATION:**

We, \_\_\_\_\_, ( the "employee-beneficiary") and, \_\_\_\_\_, (the "domestic partner), each declare that we are domestic partners and certify that our domestic partnership meets each and every one of the following criteria:

### **II. STATUS**

1. The employee-beneficiary and the domestic partner intend to remain in a domestic partnership with each other indefinitely.
2. The employee-beneficiary and the domestic partner have a common residence and intend to reside together indefinitely.
3. The employee-beneficiary and the domestic partner are and agree to be jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership.
4. Neither the employee-beneficiary nor the domestic partner is married or a member of another domestic partnership.
5. The employee-beneficiary and the domestic partner are not related by blood in a way that would prevent them from being married to each other in the State of Hawaii.
6. The employee-beneficiary and the domestic partner are both at least 18 years of age and mentally competent to contract.
7. The consent to the domestic partnership by the employee-beneficiary or the domestic partner has not been obtained by force, duress or fraud.
8. The employee-beneficiary and the domestic partner hereby agree to sign and file with the EUTF any and all declarations of domestic partnership and/or verifications of eligibility as the EUTF board may from time to time prescribe.

### **III. DEPENDENT CHILDREN OF DOMESTIC PARTNER**

We understand that dependent children of the domestic partner may be covered by the EUTF's health benefits plans if they meet all of the eligibility requirements for dependent-beneficiary coverage in such plans, e.g., be unmarried, under the age of nineteen or under the age of twenty-four and a full-time student, and be primarily dependent on the employee-beneficiary and/or domestic partner for support.

### **IV. CHANGE IN DOMESTIC PARTNERSHIP:**

1. We understand that we have an obligation to notify the EUTF by filing a Declaration of Termination of Domestic Partnership if there is any change in our domestic partnership status as a result of: (a) any of the certifications in part II of this Declaration ceasing to be true; (b) the death of the domestic partner; or (c) the termination or dissolution of our

domestic partnership. We will notify the EUTF as soon as possible of such change. The form for making this notification is available from the Human Resource Department.

2. We understand that coverage of the domestic partner and the domestic partner's dependent children (obtained as a result of completion of this Declaration) will be terminated upon the EUTF's receipt of a notice of change in our domestic partnership or upon the EUTF's receipt of any other proper notification requesting termination of such coverage .

**V. ACKNOWLEDGMENTS:**

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in this Declaration or for failure to notify the EUTF of changed circumstances as required in Section IV above. I, the undersigned employee-beneficiary, further understand that falsification of information in this Declaration, or failure to notify the EUTF, of changed circumstances pursuant to Section IV above, may lead to disciplinary action against me, including discharge from employment.
2. We have provided the information in this Declaration for use by the EUTF for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree that the EUTF is not legally required to extend any such benefits. We understand that the information provided in this Declaration will be treated as confidential by the EUTF but will be subject to disclosure; (a) upon the express written authorization of the undersigned employee, (b) upon request of the insurer or plan administrator, or (c) if otherwise required by law.
3. We understand that this Declaration may have legal implications relating, for example, to our ownership of property, qualifications required to pay premiums with pretax funds, or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.

We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

\_\_\_\_\_  
Employee-Beneficiary Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Domestic Partner Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_

\_\_\_\_\_  
Employee-Beneficiary & Domestic Partner Address

## AFFIDAVIT OF “DEPENDENCY” FOR TAX PURPOSES

**EXPLANATION:** Under Section 152(a) of the Internal Revenue Code, the term “dependent” means, in relevant part, an individual who, for the taxable year of the taxpayer, has as his or her principal place of abode the home of the taxpayer and is a member of the taxpayer’s household.

We, \_\_\_\_\_ (the “Employee-Beneficiary”) and \_\_\_\_\_ (the “Domestic Partner”) being duly sworn, say:

1. For the current taxable year of the Employee-Beneficiary, over half of the Domestic Partner’s support is received from the Employee-Beneficiary.
2. For the current taxable year of the Employee-Beneficiary, the Domestic Partner has as his or her principal place of abode the home of the Employee-Beneficiary.
3. For the current taxable year of the Employee-Beneficiary, the Domestic partner is a member of the Employee-Beneficiary’s household.
4. The Domestic Partner is a citizen of \_\_\_\_\_ (Country).

If the answer above was United States, skip to Part 5. If not, answer the following questions:

The Domestic Partner is currently a “resident” of \_\_\_\_\_ (Country).

The Domestic Partner is currently lawfully present in the United States under the following type of visa: \_\_\_\_\_.

**EXPLANATION:** Under Section 152(b)(3) of the Internal Revenue Code, a “dependent” must be either (1) a citizen or national of the United States or (2) a “resident” of the United States or of a country contiguous to the United States. Under Section 7701 (b)(3) of the Internal Revenue Code, an alien is treated as a “resident” of the United States if and only if such individual is (1) lawfully admitted for permanent residence in the United States or (2) meets a “substantial presence” test. The following individuals are not “residents” of the United States for tax purposes and, thus can never be “dependents” for tax purposes:

- A. A foreign government-related individual temporarily present in the United States on a diplomatic or consular visa, a full-time employee of an International organization, or a family member of such person.
- B. A teacher or trainee temporarily present in the United States.
- C. A student temporarily present in the United States.
- D. A professional athlete temporarily in the United States to compete in a charitable sports event.

If the type of visa is “permanent resident” skip to Part 5. If not, answer the following questions.

The actual number of days the Domestic Partner has been lawfully present in the United States during the current year and the 2 preceding years is:

\_\_\_\_\_ (Number of days in USA, current year)

\_\_\_\_\_ (Number of days in USA, 1<sup>st</sup> preceding year)

\_\_\_\_\_ (Number of days in USA, 2<sup>nd</sup> preceding year)

**EXPLANATION:** Section 152 (b)(5) of the Internal Revenue Code provides that 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 a violation of local law.

5. Our state of permanent residence for purposes of the test required by Section 1529 (b)(5) of the Internal Revenue Code is \_\_\_\_\_.  
(State)
6. We understand that if the Domestic Partner is not a “dependent” of the Employee-Beneficiary, we may incur various tax liabilities in connection with obtaining health care coverage for the Domestic Partner. We therefore agree to notify the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) within 10 days if there is any change in the Domestic Partner’s status as a “dependent” of the Employee-Beneficiary. In addition, we shall indemnify and hold the EUTF harmless for any taxes, tax related penalties, or interest imposed upon the EUTF as a result of providing Domestic Partner coverage to us, including any taxes, tax related penalties, or interest imposed as a result of our taking the position the Domestic Partner is a “dependent” of the Employee-Beneficiary for tax purposes.
7. We agree that each of us is jointly and individually responsible for reimbursement of benefits and expenses, including interest, attorney’s fees, and collection costs as a result of any false or misleading statement contained in this affidavit and related applications and submissions to the EUTF.

This section to be completed in the presence of a Notary

Each of us affirms under penalty of perjury under the laws of the State of Hawaii that we are the respective undersigned signatories, the statements in this affidavit are true to the best of our knowledge, and this affidavit and related application instruments are the free act and deed of each of us.

\_\_\_\_\_  
Employee-Beneficiary's Signature

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

\_\_\_\_\_  
Print Employee-Beneficiary's  
Name

\_\_\_\_\_  
Print Domestic Partner's Name

\_\_\_\_\_  
Employee-Beneficiary SS#

\_\_\_\_\_  
Domestic Partner's SS#

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Notary Public, State of Hawaii

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



State of Hawaii  
 Department of Human Resources Development  
 Premium Conversion Plan

**Domestic Partnership Reference Chart**

The Employer-Union Health Benefits Trust Fund is now extending health benefits plan coverage to domestic partners and children of domestic partners, provided they meet the eligibility requirements that the EUTF has established. Although the domestic partner and their dependents are eligible for health coverage, they may not be eligible to deduct all of their premium contributions on a pre-tax basis via the Premium Conversion Plan (PCP). As such, in some cases, portions of the premiums for their health plans shall be done on an after-tax basis if the domestic partner is not a **qualified dependent** under Section 152 of the Internal Revenue Code, (refer to the Premium Conversion Plan Domestic Partnership Acknowledgement Form).

To determine how to process your employee's forms, should he/she wish to participate in the PCP, the chart below is provided to you as an easy reference guide.

Members enrolled in Health Plan for family coverage:	Is the domestic partner a <b>qualified dependent</b> under Section 152 of the IRC?	How to Process
Employee & Domestic Partner	NO	PCP for the amount equivalent to the <b>Self</b> Health Plan; Non-PCP for the difference between the Self & Family premium contribution amounts.
Employee & Domestic Partner	YES	Employee has the option to have: PCP for the entire Family premium contribution amount <sup>1</sup> ; or, PCP for the amount equivalent to the Self contribution amount and non-PCP for the difference between self & family premium contribution amount
Employee, Employee's Children, & Domestic Partner	(NOT NECESSARY TO DETERMINE SINCE CHILDREN ALREADY QUALIFY FOR FAMILY COVERAGE)	PCP for the entire Family premium contribution amount.

<sup>1</sup> Section 125 of the Internal Revenue Code, which governs the PCP, does not recognize domestic partners, therefore, once the employee enrolls in the PCP for the family premium contribution amount, should there be any changes with regard to the domestic partner, the employee must wait until the next annual PCP open enrollment period to make any changes or cancellation.



State of Hawaii  
Premium Conversion Plan  
**Domestic Partnership Acknowledgement Form**

If you are eligible to enroll your domestic partner in your Health Plan for Family coverage, *and* you would like to enroll in the **Premium Conversion Plan (PCP)** to have your Health Plan premium contributions deducted from your paycheck on a pre-tax basis, please check one of the boxes below to indicate whether you want the **PCP** pre-tax benefit to be used for just the **Self** amount of your contributions which applies to you only, or for the entire **Family** amount of your contributions which applies to both you and your domestic partner.

- Please enroll me in the PCP so that only the amount equivalent to the **Self** Health Plan premium contributions can be paid using **pre-tax** payroll deducted monies to the extent permitted. I understand that the difference between the Self and Family premium contribution amounts will be paid with **after-tax** payroll monies.
  
- Please enroll me in the PCP so that the full amount of my **Family** Health Plan premium contributions can be paid using **pre-tax** payroll deducted monies to the extent permitted. My domestic partner is a **qualified dependent**, as defined under Section 152 of the Internal Revenue Code (IRC). **IMPORTANT: I understand that I will not be able to change or cancel my PCP enrollment during the plan year if there should be any changes with regard to my domestic partner and that this is because another section of the IRC which governs the PCP (Section 125), does not recognize domestic partner relationships. As such, I understand that I will only be able to change or cancel my PCP enrollment during the annual PCP Open Enrollment Periods.**

I also understand that **each** of the following requirements must be met for my domestic partner to be considered a **qualified dependent** under Section 152 of the IRC:

1. My domestic partner and I must live together for the full taxable year from January 1 through December 31, except for temporary absences for reasons such as vacation, military service, or education.
2. My domestic partner must be a citizen or resident of the United States.
3. My domestic partner must receive more than half of his/her support from me. {Note: The rules for determining support are complicated and are more involved than just determining who the "primary breadwinner" is. To help you determine whether you provide more than half of your domestic partner's support, an IRC worksheet is attached for your reference.}

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Department

\_\_\_\_\_  
Phone Number

## WORKSHEET TO DETERMINE DEPENDENT STATUS

(Worksheet modeled after the Internal Revenue Service worksheet in Publication 17)

### IMPORTANT

You can use this worksheet to determine whether your domestic partner qualifies as a dependent under Section 152 of the Internal Revenue Code (in general, your domestic partner must receive more than half of his or her support from you).

<b>Funds Belonging to your Domestic Partner</b>	
1. Total funds belonging to your domestic partner, including income received and amounts borrowed during the year, plus the amount in savings and other accounts at the beginning of the year.	\$
2. Amount of income used for support	\$
3. Amount of income used for other purposes	\$
4. Amount in savings and other accounts at the end of the year.	\$
(The total of lines 2, 3, and 4 should equal line 1)	\$
<b>Expenses for Entire Household (Where You and Your Domestic Partner Lived)</b>	
5. Lodging (complete either a or b)	
a. Rent paid	\$
b. If not rented, show fair rental value of home. If your domestic partner owned the home, include this amount on line 19.	\$
6. Food	\$
7. Utilities (heat, light, water, etc., not included on line 5a or 5b)	\$
8. Repairs (not included in 5a or 5b)	\$
9. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance).	\$
10. Total household expenses (add lines 5 through 9)	\$
11. Total number of persons who lived in household	
<b>Expenses for Your Domestic Partner</b>	
12. Each person's part of the household expenses (line 10 divided by line 11)	\$
13. Clothing	\$
14. Education	\$
15. Medical and Dental	\$
16. Travel and recreation	\$
17. Other (please specify)	\$
18. Total cost of support for the year (Add lines 12 through 17)	\$
<b>Did You Provide More Than Half?</b>	
19. Amount your Domestic Partner provided for his/her own support (Line 2, plus line 5b if your domestic partner owned the home)	\$
20. Amount that others added to your domestic partner's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts included on line 1)	\$
21. Amount <b>you</b> provided for your domestic partner's support (line 18 minus lines 19 and 20)	\$
22. 50% of line 18	\$
Is line 21 more than line 22?	
<p><b>Yes.</b> Your domestic partner qualifies as a dependent under Section 152 of the IRC. You are able to deduct your domestic partner's portion of health plan premium contributions on a pre-tax basis.</p> <p><b>No.</b> Your domestic partner does not qualify as a dependent. Your domestic partner's portion of health plan premium contributions must be deducted on an after-tax basis.</p>	