Marion County
2024
Domestic Partner
Information Packet

<u>Forms included in this packet</u>:

Affidavit of Domestic Partnership

Statement of Termination of Domestic Partner's Health Coverage

Declaration of Domestic Partner Tax-Dependent Status

Statement of Termination of Domestic Partner Tax-Dependent Status

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DOMESTIC PARTNER BENEFITS

Marion County offers medical and dental insurance coverage to all of its benefits-eligible employees' domestic partners and their legal dependents providing they meet the eligibility requirements outlined below and the employee submits the appropriate form as specified in the enrollment section to Employee Benefits in Human Resources within the required time limit. Domestic partners and their legal dependents are eligible for the same health benefits under the same conditions as provided to spouses and legal dependents of married employees.

In this packet you will find an overview of the Marion County Domestic Partner Benefits, important facts and answers to frequently asked questions about domestic partner benefits, the taxable values for the domestic partner coverage on the health insurance plans, and the required forms you will need to enroll your eligible domestic partner.

ELIGIBILITY

Same Gender and Opposite Gender Domestic Partners (Not Married): An eligible employee may enroll a domestic partner either by Affidavit of Domestic Partnership or by providing a copy of the Certificate of Registered Domestic Partnership. Either form is provided in addition to a health insurance enrollment form. Employees enrolling a domestic partner or domestic partner's children would pay imputed federal and state income taxes on the value of the domestic partner or domestic partner's children's health coverage.

Affidavit of Domestic Partnership:
Eligible employees may elect coverage for a domestic partner when all of the following criteria have been satisfied by both the employee and the domestic partner:

1. Are 18 years of age or older;
2. Are not legally married to anyone;
3. Are each other's sole domestic partner living together in a spousal equivalent relationship;
4. Have shared the same regular permanent residence for at least twelve (12) months immediately preceding the date of the required affidavit or declaration and intend to continue to do so indefinitely;
5. Are financially interdependent and jointly responsible for "basic living expenses".

   "Basic living expenses" means the cost of basic food, shelter and other expenses. You and your domestic partner need not contribute equally or jointly to the cost of these expenses as long as you agree that both are responsible for the cost.
6. Are not related by blood so close as to bar marriage in the State of Oregon and are mentally competent to consent to a contract.

Certificate of Registered Domestic Partnership:
Provide a copy of the Certificate of Registered Domestic Partnership issued by an Oregon County Clerk's Office as described in ORS 106.

Legal dependents of domestic partners are eligible if they meet the requirements of an eligible dependent as defined by Marion County's Benefit Plan Rules and the IRS. In summary, an eligible dependent is a child under the age of 26. Please refer to the Benefit Plan Rules for more details.

Tax Dependents: In order for a domestic partner to be recognized as a tax-qualified dependent, the employee must provide more than one-half of the domestic partner's support and the employee and domestic partner must share the same principal place of residence. A completed Declaration of Domestic Partner Tax-Dependent Status must be submitted to Employee Benefits in Human Resources in order to avoid paying the taxes on the value of the domestic partner's health insurance.

ENROLLMENT

- **Registered Domestic Partners*:** If you and your domestic partner are registered domestic partners, you are required to provide a copy of your Declaration of Domestic Partnership.

  ***Registered domestic partners are same gender domestic partners who have filed for and have received a Declaration of Domestic Partnership from a county clerk in the State of Oregon.**

- **Non-Registered Domestic Partners:** If you and your domestic partner are opposite gender partners, are same gender domestic partners who are not registered, or are same gender partners who have registered in another state; you will need to complete the Affidavit of Domestic Partnership, which you will find in the back of this packet.

- **Tax-Qualified Dependent:** If your domestic partner qualifies as a tax dependent, you must complete and return the Declaration of Domestic Partner Tax-Dependent Status form along with the Affidavit of Domestic Partnership form, in order to not be taxed on the value of the employee's health insurance.

New Employees

If you are a new employee, please submit the appropriate domestic partner form(s) with your Marion County Health Plans Enrollment/Change Form (located at the end of this packet), to Human Resources - Employee Benefits within one week of hire.

Current Employees Already Enrolled on the Health Plans

You may enroll your domestic partner during the year at the time your partner first meets the criteria of eligibility. Within 30 calendar days of the date your partner is eligible, you must complete and submit a new Marion County Health Plans Enrollment/Change Form (located at the end of this packet), plus the appropriate domestic partner form, in order to add your domestic partner. Submit your forms to Human Resources - Employee Benefits (within 31 calendar days of eligibility).

Please Note: If you do not enroll your domestic partner when first eligible, you may enroll your partner during the annual open enrollment period. Coverage will be effective the first day of the new plan year, which is January 1.

Where should I send the required forms?

Mailing Address: Marion County Employee Benefits
P.O. Box 14500, Salem, OR 97309-5036

Drop Off In Person: Courthouse Square: 555 Court St NE, 4th Floor, Room 4250, Salem

If you have questions on domestic partner benefits, please contact Marion County Employee Benefits staff in Human Resources at MCEmployeeBenefits@co.marion.or.us

TAXABLE VALUE OF HEALTH INSURANCE COVERAGE

FOR DOMESTIC PARTNERS

Effective January 1 – December 31, 2024

According to the Internal Revenue Service, health insurance coverage for domestic partners is a taxable benefit to the employee unless a domestic partner qualifies as a tax-qualified dependent under IRS rules. Marion County employees who enroll domestic partners on their health plans who are not tax-qualified dependents will have to pay income taxes on the fair market value of the health insurance coverage their domestic partners receive. The value of the domestic partner insurance coverage is considered earnings, is included in the employee's gross taxable income, and is subject to state and federal income tax and FICA withholding.

The taxable value of the domestic partner coverage will depend on the health plan in which the employee is enrolled and the number of dependents enrolled, if any. On the first and second paychecks of each month, the appropriate amount will be added to the employee's taxable gross wages based on the health plan election and family status. After the wages are taxed, the value of the health coverage is then removed.

The chart below shows the twice-monthly taxable values for our medical and dental plans for both MC and MCLEA (Law Enforcement Association) employees.

Twice-Monthly Taxable Value of Marion County Health Insurance for Domestic Partners - Effective January 1 through December 31, 2024

MCEA, MCJEA, FOPPO, ONA, Unit 12, & Management		
	Domestic Partner	Partner & Dependents
PacificSource PPO Traditional Plan	$377.46	$775.78
PacificSource PPO HDHP/HSA Plan*	$272.82	$646.12
Kaiser HMO Plan	$374.02	$748.03
Delta Dental Plan	$24.61	$52.20
Kaiser Dental Plan	$27.76	$55.52

Law Enforcement Association (MCLEA)		
	Domestic Partner	Partner & Dependents
PacificSource PPO Plan	$428.50	$907.70
Kaiser HMO Plan	$369.17	$738.34
Delta Dental Plan	$27.78	$58.91
Kaiser Dental Plan	$35.38	$70.75

***PacificSource PPO/HSA Plan**: Domestic Partners may be covered on the employee's PacificSource's Health PPO/HSA Plan (the high deductible plan with the Heath Savings Account); however, the un-reimbursed healthcare expenses for the domestic partner may **not** be paid for from the employee's Health Savings Account, unless the domestic partner is a qualified tax-dependent. If a Domestic Partner is not a tax-dependent, but is "eligible" according to IRS definition, the Domestic Partner may establish his/her own Health Savings Account from which to pay qualified healthcare expenses. We advise you to discuss this with your tax advisor.

IMPORTANT FACTS REGARDING DOMESTIC PARTNERSHIP

Monthly Premium Charges: If an employee chooses a medical and dental plan option, which requires a monthly employee premium share, the premium contributions will be taken as a bi-weekly payroll deduction. The payroll deductions for employees with domestic partners cannot be taken on a pre-tax basis, as explained under the Flexible Spending Account section, unless the domestic partner is a tax-qualified dependent.

Flexible Spending Accounts: Because the IRS does not recognize domestic partners to be qualified dependents under IRS rules unless they are tax-qualified dependents, Flexible Spending Accounts cannot be used for pre-tax premium deduction for domestic partner coverage or for reimbursement of the domestic partners' or their dependents' healthcare expenses.

Termination of Eligibility: Upon termination of the domestic partner relationship, or if your domestic partner no longer meets the criteria for eligibility or experiences a family status change (such as acquiring health coverage through his/her employer), the employee may drop the domestic partner's coverage. The employee must notify Employee Benefits within 30 calendar days by submitting a Statement of Termination of Domestic Partnership and a new Health Plans Enrollment/Change Form. Payroll deductions for the imputed value taxes will be discontinued once the forms are received by Employee Benefits.

After such termination, you may not add a new domestic partner earlier than twelve (12) months from the date the Statement of Termination of Domestic Partnership was submitted.

Retiree or COBRA Continuation Coverage: The domestic partner and legal dependents of an employee who elects coverage under COBRA (continuation of coverage) may continue their coverage for as long as the employee continues on this coverage.

The domestic partner and legal dependents of a retiree who elects to continue on the Retiree Plan are eligible to continue coverage as long as they are under age 65. Retired employees covered under a PERS-sponsored health plan would need to contact PERS for details on domestic partner coverage.

FREQUENTLY ASKED QUESTIONS

Q: I submitted the required forms to Employee Benefits. What happens next?
A: Marion County Benefits Staff will forward your forms to the appropriate insurance company for processing. ID cards will be issued for the newly covered member(s). If you do not receive a new ID card(s) by your effective date, please contact your carrier.

Delta Dental: (888)-217-2325
Kaiser Permanente: (503)-361-5400 in Salem or (800)-813-2000
PacificSource: (888)-977-9299

Q: Do the records of employees with domestic partners receive confidential protection?
A: Yes. All benefit forms and records for all county employees are held in strict confidence.

Q: What happens if my domestic partner becomes my legal spouse?
A: You will need to provide a new Health Plans Enrollment/Change Form, proof of marriage, and a Statement of Termination of Domestic Partnership form in order to discontinue the deductions for the imputed value taxes.

Notify Employee Benefits within 30 days of the date you are married.

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Marion County

AFFIDAVIT OF DOMESTIC PARTNERSHIP

SECTION I

Employee Name: _____

Division/Department: _____ Work Phone: _____

SECTION II

I, _____, certify that:
(Employee Name)

My domestic partner is _____ and we reside together as a
(Name of Domestic Partner)

non-married couple at: _____
(Address)

_____

The effective date of this domestic partnership (the date we began living together) is _____.
(Month and Year)

I am also enrolling the following children of my domestic partner:

_____

_____

In relationship to this domestic partnership, I affirm that my partner and I meet all the criteria described below:

1. Are 18 years of age or older;
2. Are not legally married to anyone;
3. Are each other's sole domestic partner living together in a spousal equivalent relationship;
4. Have shared the same regular permanent residence for at least twelve (12) months immediately preceding the date of this Affidavit of Domestic Partnership, and intend to continue to do so indefinitely;
5. Are financially interdependent and jointly responsible for "basic living expenses"*; and
6. Are not related by blood so close as to bar marriage in the State of Oregon and are mentally competent to consent to contract when our domestic partnership began.

* For purposes of this Affidavit of Domestic Partnership (Affidavit), "Basic living expenses" means the cost of basic food, shelter and other expenses. You and your domestic partner need not contribute equally or jointly to the costs of these expenses as long as you agree that both are responsible for the cost.

SECTION III

A. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change in circumstances attested to in this Affidavit.

B. I agree to notify Human Resources - Employee Benefits within 31 calendar days if there is any change of circumstances attested to in this Affidavit by submitting a Statement of Termination of Domestic Partnership.

C. After such termination, I understand that an application to add a new domestic partner cannot be filed earlier than twelve (12) months from the date a statement of Termination of Domestic Partnership was submitted.

Continued on Reverse →

Affidavit of Domestic Partnership – continued

SECTION IV

I understand that the information in this Affidavit will be used by Marion County for the sole purpose of determining eligibility for obtaining benefits and that any other use of the information will be subject to disclosure only upon my express written authorization or if otherwise required by law.

I understand that signing this Affidavit may have legal implications beyond the extension of insurance coverage for which it is intended.

I understand that it is my responsibility to provide Marion County with documents establishing that the above-named person is my eligible domestic partner if the county requests such documentation. If I do not produce documentation within 30 calendar days of the request, Marion County may elect to retroactively rescind my dependent coverage, and I may be required to reimburse the county for any expenditure made by the county for the above named domestic partner, including but not limited to premiums, medical claims, administrative charges, and attorney's fees.

I understand that any person/employer/company who may suffer any loss because of a false statement contained in this Affidavit may bring a civil action against me to recover their losses including reasonable attorney's fees.

I understand that inclusion of false or misleading information in this Affidavit may lead to disciplinary action up to and including discharge from employment, and I attest that the certification I have provided herein is true and correct.

Notice: Signing this Affidavit may or may not have legal implications affecting relations between domestic partners beyond the extension of medical or dental insurance coverage for which it is intended. If you desire further information concerning the possible legal consequences of signing this form, please consult an attorney.

_____ _____

Employee's Signature Date

A Marion County 'Health Plans Enrollment/Change Form' must be submitted with this Affidavit.

Complete & send to Human Resources - Employee Benefits within 30 days of above event or new hire.

Marion County
STATEMENT OF TERMINATION OF
DOMESTIC PARTNER'S HEALTH COVERAGE

I (employee)_____, affirm that the Affidavit of Domestic

Partnership attested to and signed by me on (date of original Affidavit of Domestic Partnership)

_____ shall be and is terminated as of the below date.

Termination is due to:

- ☐ Termination of domestic partnership due to change in one or more circumstances attested to in Section II of the Affidavit.
- ☐ Marriage to domestic partner.
  (Please include copy of proof of marriage with enrollment form).
- ☐ Death of domestic partner.
- ☐ Voluntary termination of coverage of domestic partner due to other insurance coverage.

Date of above event: _____

I understand that I cannot file a Statement of Domestic Partnership to enroll a new domestic partner until twelve (12) months following the receipt of this statement by my employer.

_____ _____

Signature of Employee Date

A Marion County Health Plans Enrollment/Change Form must be submitted with this Statement of Termination of Domestic Partnership.

Complete & send to Human Resouces - Employee Benefits within 30 days of the above event.

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Marion County
Declaration of Domestic Partner Tax-Dependent Status

SECTION 1

Employee Name: _____ SSN# _____

Division/Department: _____ Work Phone: _____

SECTION 11

I, _____, certify that:
(Employee Name)

My domestic partner, _____, is also my dependent.
(Name of Domestic Partner)

In relationship to this dependent status, I affirm that my domestic partner and I meet each of the conditions described below.

1. We share the same principal place of residence; and
2. I provide more than one-half of my domestic partner's support.

SECTION III

1. I understand that this Declaration of Domestic Partner Tax-Dependent Status (Declaration) shall be terminated by a change in circumstances attested to in this Declaration.
2. I agree to notify Employee Benefits within thirty (30) calendar days if there is any change of circumstances attested to in this Declaration by submitting a Statement of Termination of Dependent Status.

SECTION IV

I understand that the information in this Declaration will be used by Marion County for the sole purpose of determining the tax treatment of benefits provided to my domestic partner and that any other use of the information will be subject to disclosure only upon my express written authorization or if otherwise required by law.

I understand that signing this Declaration may have legal implications beyond the extension of insurance coverage for which it is intended.

I understand that it is my responsibility to provide Marion County with documents establishing that the above-named domestic partner is my tax-qualified dependent, if Marion County requests such documentation. If I do not produce documentation with thirty (30) calendar days of the request, Marion County may elect to retroactively rescind the tax-qualified status of my domestic partner's coverage and I may be taxed on the fair market value of the health insurance coverage provided by Marion County for my domestic partner.

I understand that if Marion County, or any other company, is found to owe taxes or incurs other damages because of a false statement contained in this Declaration, Marion County or company may bring a civil action against me to recover their losses, including reasonable attorney's fees.

I understand that inclusion of false or misleading information in the Declaration may lead to disciplinary action up to and including discharge from employment, and I attest that the certification I have provided herein in is true and correct.

Employee's Signature Date

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Marion County

Statement of Termination of Domestic Partner Tax-Dependent Status

Complete and send this form to Human Resources - Employee Benefits.

I (employee) _____ state that my domestic partner no longer qualifies as my tax-qualified dependent, effective as of _____.

_____ _____

Signature of Employee Date

HEALTH PLANS ENROLLMENT/CHANGE FORM

Please use black or blue ink if completing a paper form.
Email completed forms to: MCEmployeeBenefits@co.marion.or.us

Effective Date ☐

A. PLAN OPTIONS

You must make a selection for medical AND dental. Please note: Unit 5/MCLEA employees are not eligible for the PacificSource High Dedeuctible Health Plan (HDHP).

MEDICAL INSURANCE OPTIONS:	DENTAL INSURANCE OPTIONS:
☐ Kaiser HMO	☐ Kaiser Dental HMO
☐ PacificSource Traditional PPO	☐ Delta Dental PPO
☐ PacificSource HDHP-**Unit 5/MCLEA INELIGIBLE**	

B. EMPLOYEE INFORMATION

Last Name | First Name | MI | Birth Date (MM/DD/YY) | Gender

Home Address | Social Security # | Marital Status

City | State | Zip | Phone Number

Department | Date of Hire | Unit | Employee #

C. REASON FOR COMPLETING FORM (Check all that apply)

☐ **New Hire** ☐ **Open Enrollment**

☐ **Name Change** ☐ **Address Change**

☐ **Eligibility or Status Change**

Adding Dependent(s)

Please complete dependent information on Page 2

Form must be turned in within 30 days of event

Date of Event: _____

☐ **Birth** ☐ **Marriage *** ☐ **Adoption ***

☐ **Domestic Partner *** **Other Reason:** _____

*** Include Marriage Certificate, Declaration of Oregon Registered Domestic Partnership, Affidavit of Domestic Partnership, or Adoption Documentation.**

Deleting Dependent(s)

Form must be turned in within 30 days of event

Date of Event: _____

☐ **Term Domestic Partner **** ☐ **Divorce *** ☐ **Death**

Other Reason: _____

*** Include the page on your divorce decree showing date divorce was granted.**

**** Include the Statement of Domestic Partner Cvg. Termination.**

Name to Delete: _____

Address: _____

Name to Delete: _____

Address: _____

I apply for membership for the persons listed above and agree that we shall abide by the provisions of the applicable health plan selected. I certify that the information on this application is true and correct. I hereby authorize any medical care institution or medical provider to give my insurance carriers any information related to the physical or mental condition, medical history, or medical treatment of me or my family members requested in the underwriting of my application or in administering claims under my plan(s). This authorization will remain valid so long as I remain eligible for benefits. Furthermore, I hereby authorize Marion County to make any applicable deductions from my pay for insurance premiums. I understand this election is binding until revoked or modified by me during an open enrollment or upon an event that qualifies for a plan change. I will be automatically enrolled in the pre-tax Employee Insurance Premium Contribution Flexible Spending Account for any premium contributions. I have read and agree to the Employee Insurance Premium Contribution Account Agreement information on page 2 of this form. Unless I specifically contact Employee Benefits and sign that I want my premium deductions taken on a post-tax basis, I understand that my premium deductions will be taken pre-tax.

Employee Signature _____ Date _____

☐ No Dependents

☐ Dependents on other side

Rev. 10/11/2022

Employee Name: ______________________ Employee #: ____________

D. DEPENDENT INFORMATION Please list ALL those who are eligible to be covered on your plan.

☐ Spouse ☐ Domestic Partner

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

Dependent Legal Relation: ____________

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

Dependent Legal Relation: ____________

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

Dependent Legal Relation: ____________

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

Dependent Legal Relation: ____________

Last Name	First Name	MI	Social Security #	Gender	Birth Date (MM/DD/YY)

Mailing Address - **ONLY if different from Employee's**	City	State	Zip Code	Phone **Only if different**

If any persons are covered by other insurance, including Medicare or another County Employee, please indicate who and provide name of other insurance and policy number to assist with Coordination of Benefits :

If enrolling in the pre-tax Employee Insurance Premium Contribution FSA, please read the agreement below.

Employee Insurance Premium Contribution Account Agreement

In consideration of my participation in the Flexible Spending Account (FSA) Employee Insurance Premium Contribution, I acknowledge and agree to the following:

1. ACCEPTABLE FSA PLAN TERMS: I agree to abide by the terms, conditions and provisions of the FSA contained in the plan document. I acknowledge my right to examine the plan document or obtain a copy of it by giving reasonable advance notice.

2. PLAN MODIFICATION: I have been informed that the FSA offered by my employer may be modified from time to time and I agree that my employer may cancel or amend the FSA according to their independent judgement and discretion without my consent or prior notice to me.

3. SOCIAL SECURITY: I choose to participate in the FSA despite my knowledge that my salary reduction elections may reduce my FICA withholding (Social Security) and that this may reduce my Social Security benefits upon retirement.

4. SEEK LEGAL ADVICE: I have been informed that my participation in the FSA will have tax and economic consequences to me and that before deciding to participate in the FSA, I should seek the advice of an attorney or tax consultant regarding the benefits, risks and limitations of the FSA.

5. IRREVOCABLE ELECTION: I understand I cannot change or revoke my election until the open enrollment period for the new plan year. I will be able to change my election if I have a change in status as outlined in the Plan Document. The election change must be requested within 30 days of the event and must be on account of and consistent with the change in status.