CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Domestic Partner Affidavit

California Department of Human Resources
State of California

Print Form Reset Form

Please read this affidavit carefully.

State law and/or collective bargaining agreements permit the eligibility of domestic partners for the purposes of enrollment into a state-sponsored dental, vision, and health plan. When a State employee adds a domestic partner, the employee will have an imputed tax liability based on the amount of the increase in State contribution to benefits paid for the domestic partner, unless the domestic partner is claimed as a dependent for Federal Income Tax purposes as authorized by the Internal Revenue Service.

In order to remove the imputed tax liability when enrolling a domestic partner into a State dental plan and/or health plan, California Department of Human Resources requires that this affidavit be completed and signed by the State employee.

Please complete and sign this affidavit and return it to your personnel office. Failure to return this document may cause you to incur more income tax withholding based on an increase in taxable income.

Employee Statement

Please carefully read the following paragraph and print your name and that of your domestic partner in the appropriate areas:

I, _____ , under penalty of perjury declare my domestic partner, _____ , as a dependent for the purposes of my Federal Income Taxes. I further affirm under penalty of perjury that should I no longer declare my domestic partner as a dependent for tax purposes, that I will immediately notify the State in writing of this fact. I understand that if I do not notify the State in writing immediately of the change in dependency status for my domestic partner, that I may be held liable for any taxes due based on when the dependency ended. By signing this document I also agree to permit the State upon request of an authorized representative of the California Department of Human Resources or the State Controller' Office or their designee, full access to my tax records, domestic partner filing documents and/or any other supporting documentation as needed by the State to verify dependency for Federal Income Tax purposes.

Employee Name	Social Security Number	Tax Year

_____ _____

Employee Signature Date

Employing Agency Use Only

Date Received	Received by (name)

Agency Name

PRIVACY NOTICE

This notice is provided pursuant to the Information Practices Act of 1977.

The California Department of Human Resources (CalHR), Benefits Division, and the Dental, Vision, and Health Plan Administrators are requesting the information specified on this form pursuant to Government Code Sections 1151, 1153, Section 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

The information collected will be used for administering Dental, Vision, and Health Plan Program benefits and will be disclosed to the Dental, Vision, and Health Plan administrators.

Individuals should not provide personal information that is not requested or required.

The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, CalHR will not be able to process your request for Dental, Vision, and Health Plan Program benefits.

Department Privacy Policy

The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy on CalHR's website (calhr.ca.gov).

Access to Your Information

Information provided on this form will be maintained in confidential files of CalHR for five years. Individuals have the right of access to copies of this form on request. Send requests to:

CalHR Privacy Officer
1515 S Street, North Building, Suite 500
Sacramento, California 95811-7258
916-324-0455
CalHRPrivacy@calhr.ca.gov