



# Declaration of Tax Status Alaska Benefit Plans

FOR OFFICE USE ONLY

**Toll-Free: (800) 821-2251**  
**alaska.gov/drb**

*Division of Retirement and Benefits*  
PO Box 110203  
Juneau, Alaska 99811-0203

**Juneau: 465-4460**  
TDD: (907) 465-2805  
Fax: (907) 465-3086



The State of Alaska offers coverage for same-sex partners and their eligible dependent children. In order to ensure proper tax treatment of the benefits for these dependents, the State must know the federal tax status of each dependent enrolled. The tax status of the dependent does not affect their eligibility for coverage but does impact the tax treatment of that coverage. The flowchart on the back of this form is provided to assist you in determining and verifying the federal tax status of your same-sex partner and dependent children. The chart is provided as an overview of the tax rules but given their complexity, we recommend you consult a tax advisor regarding your specific circumstances. Additional information regarding the tax implications is provided in "Retiree Important Tax Implications for Enrolling Same-sex Partners."

*List every dependent you are enrolling for health coverage on your health dependent enrollment form in this packet and indicate whether they are a federal tax dependent, or not, after following the flowchart on the back of this form.*

Member Name		Member RIN	
Health Dependent Name		Relationship to Member	Federal Tax Status
		Same-sex Partner	<input type="checkbox"/> This person <b>is</b> my tax dependent for purposes of this health plan. <input type="checkbox"/> This person <b>is not</b> my tax dependent for purposes of this health plan.
	Date of Birth		
		Child of Same-sex Partner	<input type="checkbox"/> This person <b>is</b> my tax dependent for purposes of this health plan. <input type="checkbox"/> This person <b>is not</b> my tax dependent for purposes of this health plan.
	Date of Birth		
		Child of Same-sex Partner	<input type="checkbox"/> This person <b>is</b> my tax dependent for purposes of this health plan. <input type="checkbox"/> This person <b>is not</b> my tax dependent for purposes of this health plan.
	Date of Birth		
		Child of Same-sex Partner	<input type="checkbox"/> This person <b>is</b> my tax dependent for purposes of this health plan. <input type="checkbox"/> This person <b>is not</b> my tax dependent for purposes of this health plan.
	Date of Birth		
		Child of Same-sex Partner	<input type="checkbox"/> This person <b>is</b> my tax dependent for purposes of this health plan. <input type="checkbox"/> This person <b>is not</b> my tax dependent for purposes of this health plan.
	Date of Birth		

I understand that the division has a legitimate need to know the federal income tax status of my relationship with my same-sex partner and their child/children. I certify that the information I have listed above is true. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I understand that if any information I have provided is false or misleading, it could result in termination of eligibility under the health plan. I agree to notify the Division if there is any change in these circumstances within 30 days of the change. I am aware that changes may impact the tax treatment of my coverage.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

# Declaration of Tax Status Alaska Benefit Plans

Answer the following questions for **each** person you listed on the other side of this form:

