DOMESTIC PARTNERSHIP INSTRUCTION SHEET

Due to IRS regulations Monroe #1 BOCES is required by law to collect tax on the overall portion of BOCES insurance cost for your domestic partner or same sex spouse.

What does this IRS regulation mean to me? Monroe #1 BOCES is required to report the difference for insurance costs for your domestic partner or same sex spouse as income to the government. This means the difference in total BOCES cost of insurance you would be enrolled in without your domestic partner or same sex partner vs. the BOCES cost of the plan with your domestic partner or same sex partner. That amount will be added to your gross wages and taxes will need to be paid, if required.

I am in a same sex marriage, how does this affect me? For employees who are in same sex marriage, the Federal Government does not recognize your marriage. However, New York State does. This means you will be required to pay Federal taxes on your portion of insurance for your spouse, but will be exempt from State taxes after July 24th, 2011.

I have read the above and still wish to enroll my domestic partner, what's next? Follow the steps below and print the corresponding forms from our website and submit to Human Resources.

Steps to Enroll Domestic Partner:

1) Read and submit Domestic Partnership Affidavit
2) Read and submit Domestic Partnership Questionnaire
3) Fill out Excellus Enrollment form for Med/Den within 30 days of event. Coverage to begin 1st of following month.
4) Return all documents together to Human Resources for processing

Sample:

Coverage level with DP – Sponsor	BOCES Cost for Sponsor Plan $839.03
Coverage level with NO DP – Single	BOCES Cost for Single Plan $364.70
	Difference: 474.33 x 12 months = $5691.96 additional taxable income

Please remember the taxable amount is based on what BOCES pays for your coverage, not what you pay each month. In some cases this can have significant increase in taxable income.

----------**Questionnaire- Return Bottom Portion**----------

Employee Name: _____

Coverage level **with** Domestic Partner: Sponsor ____ Family ____

Covered on Medical: Y ____ N ____ Covered on Dental: Y ____ N ____

Please list names of any children on coverage including ones that are **NOT** your legal dependents. Also, mark the line as to whether it is your child (employee) or only your domestic partner/same sex spouse or if both. This information is used to verify that we are charging you for the appropriate coverage and could significantly reduce the taxable amount you are charged.

Name	Child of Employee	Child of DP	Child of Both
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please Print Name: _____ Signature: _____ Date_____

DOMESTIC PARTNERSHIP AFFIDAVIT

This affidavit extends health and dental benefits to a significant other hereinafter referred to as a "Domestic Partner" of a qualified employee presently working at Monroe #1 BOCES. (*Domestic Partners are two adults at least 18 years of age who have chosen to share one another's lives in an intimate and committed relationship of mutual caring, who live together, and who have agreed to be jointly responsible for expenses incurred during the Domestic Partnership.)*

I ATTEST that I am presently an employee of Monroe #1 BOCES and qualify for health and dental benefits as described in Board policy and collective bargaining agreements, and meet the following criteria to apply for benefits for my Domestic Partner:

1. We are both at least eighteen (18) years of age and are competent to enter into a contract;

2. We are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which we legally reside;

3. We are not married and are not the domestic partner of anyone else in any jurisdiction;

4. We have not terminated a Domestic Partnership Affidavit, or its equivalent in this or another jurisdiction, within six (6) months immediately prior to applying for health/dental benefits.

5. We currently live in the same household, have lived in the same household continuously for a least six (6) months immediately prior to applying for health/dental coverage, and intend to continue to live in the same household indefinitely;

6. We are committed to the physical, emotional and financial care and support of each other;

7. We are financially interdependent;

8. We share with each other the common necessities and tasks of one household;

9. We agree to inform Monroe #1 BOCES, as soon as possible, if this domestic relationship should change or end; and further

10. We understand that we are subject to all standard requirements, criteria and qualifications that are set by our medical/dental insurance carriers under their contracts.

Each of us understands that if either of us has made a false statement regarding his or her qualifications as a domestic partner, or has failed to comply with the terms of this Affidavit, and Monroe #1 BOCES suffers any loss thereby, we are responsible for reimbursing Monroe #1 BOCES any losses or expenses incurred, including reasonable attorney's fees and court costs incurred in enforcement. Each of us declares under penalties of perjury that the assertions in this affidavit are true and correct to the best of our knowledge.

Date: _____

_____ (Employee Signature)

_____ (Domestic Partner Signature)

_____ Print Name

_____ Print Name

Notary Public: _____

Notary Public: _____

Rochester Area Schools Health Plan 2 - Enrollment Form

Excellus BlueCross BlueShield

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

PLEASE PRINT CLEARLY **Districts Name:**

Section 1: Subscriber Information

Type of Transaction Please √
☐ Add Subscriber ☐ Add Dependent ☐ Change of Coverage ☐ Transfer to COBRA/COBRA Effective Date:

Section 2: Subscriber, Please indicate the reason for this enrollment or change

☐ New Hire/Active Enrollment ☐ COBRA ☐ Retirement ☐ Loss of Coverage ☒ Domestic Partner/Same Sex ☐ Open Enrollment ☐ Age 65+ ☐ Address/Phone Number ☐ Last Name ☐ Remove Dependent ☐ Change in Student Status ☐ Disability

☒ Add Dependent/ Reason: ☐ Newborn ☐ Marital Status Change ☐ Adoption ☐ Marriage ☐ Same Sex Marriage

Subscriber Plan Please √
☐ Blue Point 2 Extended (EA) ☐ Blue Point 2 Select (EB) ☐ Blue Point 2 Value (EC) ☐ Dental

Type of Coverage Please √
Medical: ☐ Single ☐ Family ☐ Sub & Spouse ☐ Sub & Child ☐ Family No Spouse
Dental: ☐ Single ☐ Family ☐ Sub & Spouse ☐ Sub & Child ☐ Family No Spouse

Date of Hire/Event: **Coverage Effective Date:**

Subscriber's Last Name: **First Name:** **Middle Initial:**
Social Security #: Date of Birth: Gender ☐ M ☐ F
Mailing Address: Apt or Suite:
City: State: Zip:
Home Phone Number: Work Phone Number:
Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced/Marital Status Event Date:
Medicare # (if applicable) Part A Effective Date: Part B Effective Date:
Primary Care Physician's Last Name: First Name: Current Patient: ☐ Y ☐ N
OB/GYN's Last Name: First Name: Current Patient: ☐ Y ☐ N
Medicare Number (If applicable) Part A Effective Date: Part B Effective Date:

Spouse/ Domestic Partner Last Name: **First Name:** **M. I.**
Social Security #: Date of Birth: Gender ☐ M ☐ F
Primary Care Physician's Last Name: First Name: Current Patient: ☐ Y ☐ N
OB/GYN's Last Name: First Name: Current Patient: ☐ Y ☐ N
Medicare Number (If applicable) Part A Effective Date: Part B Effective Date:

Dependent's Last Name: **First Name:** **M. I.**
Social Security #: Date of Birth: Gender ☐ M ☐ F
Primary Care Physician's Last Name: First Name: Current Patient: ☐ Y ☐ N
OB/GYN's Last Name: First Name: Current Patient: ☐ Y ☐ N
Dental Only: Full Time Student ☐ N ☐ Y If yes, indicate College/University Name:
Expected Graduation date: Credit Hours:
Medicare Number (If applicable) Part A Effective Date: Part B Effective Date:

Subscriber's Last Name: **pg of pg**

Dependent's Last Name:	**First Name:**	**M. I.**
Social Security #:	Date of Birth:	Gender ☐ M ☐ F
Primary Care Physician's Last Name:	First Name:	Current Patient: ☐ Y ☐ N
OB/GYN's Last Name:	First Name:	Current Patient: ☐ Y ☐ N
Dental Only: Full Time Student ☐ N ☐ Y If yes, indicate College/University Name:		
Expected Graduation date:	Credit Hours:	
Medicare Number (If applicable)	Part A Effective Date:	Part B Effective Date:
Dependent's Last Name:	**First Name:**	**M. I.**
Social Security #:	Date of Birth:	Gender ☐ M ☐ F
Primary Care Physician's Last Name:	First Name:	Current Patient: ☐ Y ☐ N
OB/GYN's Last Name:	First Name:	Current Patient: ☐ Y ☐ N
Dental Only: Full Time Student ☐ N ☐ Y If yes, indicate College/University Name:		
Expected Graduation date:	Credit Hours:	
Medicare Number (If applicable)	Part A Effective Date:	Part B Effective Date:
Dependent's Last Name:	**First Name:**	**M. I.**
Social Security #:	Date of Birth:	Gender ☐ M ☐ F
Primary Care Physician's Last Name:	First Name:	Current Patient: ☐ Y ☐ N
OB/GYN's Last Name:	First Name:	Current Patient: ☐ Y ☐ N
Dental Only: Full Time Student ☐ N ☐ Y If yes, indicate College/University Name:		
Expected Graduation date:	Credit Hours:	
Medicare Number (If applicable)	Part A Effective Date:	Part B Effective Date:

Section 3 In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer

Have you, your spouse or any enrolled dependent had other coverage within the last 63 days? Health? ☐ N ☐ Y / Dental? ☐ N ☐ Y

If answering "Yes", are you keeping the additional health and/or dental coverage? Health? ☐ N ☐ Y/Dental? ☐ N ☐ Y Who did the other plan cover? ☐ Self ☐ Spouse ☐ Child(ren)

Other insurance carrier name:	Other insurance name of policyholder:

Policy ID #	Effective Date:	Termination date:

Section 4 Release/Subscriber signature required. You must sign and date this form to be eligible for insurance.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature.. **Date**..

Section 5 Group Employer Information **(This section should be completed by the Group Benefits Administrator. This application cannot be processed without this information and a Signature.)**

Was the employee subject to a waiting period before enrolling in your employer health plan? ☐ N ☐ Y If yes, what was the start date: And the end date:

Medical Group # 00044333	**Subgroup#**	**Class#**	**Department Code:**
Dental Group #	**Subgroup#**	**PKG#**	

Group Administrator Signature .... **Date** ....

Subscriber's Last Name: .... **pg of** .... **pg**

Please return form to your Group Benefits Administrator.

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the event date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request

To process a Subscriber or Dependent cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible	COBRA End Date
Commercial	Subscriber Request
COBRA Begin Date	Subscriber Deceased
COBRA Handicapped/Disabled Date	Spouse's Insurance
Transfer to Traditional	Medicaid
Transfer to HMO	Medicare
Transfer to POS	

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage – when permitted by law	COBRA Begin Date
Dependent Over Age	Subscriber Request
Deceased	Divorce
Ineligible Student	Medicare

COVERAGE TYPE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than four dependents please use an additional form.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the eligible child age for your employer group:
  - natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

  Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.

  I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative.

Or, visit us at: www.excellusbcbs.com