

University of Wisconsin System

Instructions for completing the Dependent Tax Status Change Form for State Group Health Insurance

You must submit this form to your institution/campus Payroll and Benefit Office if you are changing the tax status of a dependent.

SECTION 1 – APPLICANT INFORMATION

1. *Print your responses clearly and legibly.*
2. Enter your complete name (including your previous name, if applicable), your home address, and your home and daytime telephone numbers in the spaces provided.
3. Eligibility Status: Check the box which describes your status as an applicant.
4. A tax status change is made for an entire tax year. Because health insurance premiums are paid one month in advance of coverage, a tax status change made between November 1 and October 31 is effective for the tax year starting January 1 within this time period.

SECTION 2 – TAX STATUS CHANGE

1. List only the dependent(s) whose tax status is being changed.
2. Indicate “Yes” or “No” if your domestic partner and/or dependent child is considered a “tax dependent” under federal tax law. You do not need to complete this box for your spouse. Note there may be tax consequences to you when you cover dependents (i.e., domestic partners and children) that are not dependent on you for at least 50% of their support.

Please consult your tax advisor when determining the tax status of dependents. See IRS Publication 501 (2009), located online at <http://www.irs.gov/pub/irs-pdf/p501.pdf>. Note: The gross income limit does not apply for purposes of determining tax dependent status when you are covering the person on your health insurance policy.

Review the Tax Dependent Worksheet located at http://www.bussvc.wisc.edu/ecbs/Tax_Dependent_Status_Worksheet.pdf to determine if your adult child or domestic partner is a tax dependent.

For domestic partner health insurance information, please review Domestic Partner Benefits (ET-2370), located at <http://etf.wi.gov/publications/et2370.pdf>

For eligible adult child health insurance information, please review Benefit Eligibility for Adult Children up to Age 27, located at http://etf.wi.gov/publications/dependent_mandate_2010.pdf

SECTION 3 – SIGNATURE

1. Read the **TERMS AND CONDITIONS** below.
2. Sign and date the form.

TERMS AND CONDITIONS

1. Under the penalties of perjury, I declare that I have examined this Dependent Tax Status Change Form and to the best of my knowledge and belief, all statements and answers are true, correct, and complete. (This form is not valid unless you sign it.)
2. Any children, as defined in the contract, listed on this application are not married and not eligible for coverage under a group health insurance plan that is offered by their employer for which the amount of their premium contribution is not greater than the premium amount for their coverage under this program. Children may be covered through the end of the month in which they turn 27. Children may also be covered beyond age 27 if they:
 - have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or
 - are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education; and if the adult child has applied for full-time student status at an institution of higher education, within 12 months after completing active duty; and if the adult child is called more than once in four years of the first call to active duty, insurers and self-insured health plans may only use the adult child's age at the time of the first call to active duty to determine eligibility.
3. I understand that if my insured domestic partner and/or adult dependent children of my domestic partner are not considered tax dependents for group health insurance purposes under federal tax law, my income will include the fair market value of the health insurance benefits provided to my domestic partner and/or adult dependent children of my domestic partner. I understand that this may affect my federal and state taxable income and increase my tax liability.

I understand that if my insured adult child turning age 27 in the current calendar year is not considered a tax dependent for group health insurance purposes under federal tax law, my income will include the fair market value of the health insurance benefits provided to my adult children. I understand that this may affect my federal and state taxable income and increase my tax liability.

I understand that if my insured adult children age 26 or under are not considered tax dependents for group health insurance purposes under State of Wisconsin tax law, my income will include the fair market value of health insurance benefits provided to my adult children. I understand that this may affect my state of Wisconsin taxable income and increase my state tax liability.
4. I understand that it is my responsibility to notify my employer if there is a change affecting my coverage. This form applies to a change in the “tax dependent” status of my domestic partner and/or dependent children. Upon request, I agree to provide any documentation that ETF or my employer deems necessary to substantiate my eligibility or that of my dependents.

**DEPENDENT TAX STATUS CHANGE FORM
FOR STATE GROUP HEALTH INSURANCE**

Employer Notes

Use this form if you are ONLY making dependent tax status changes.
Tax status changes due to qualifying events and all other changes should be submitted on the Health Insurance Application/Change Form (ET-2301).

You may want to consult your tax advisor when determining the tax status of dependents.

1. UW EMPLOYEE INFORMATION				
Employee – Last Name	First	Middle	Previous Name	Social Security Number
Address—Street and No.	Cit	y	State	Zip Code
Home Telephone No.		Daytime Telephone No.		
ELIGIBILITY STATUS (check one) <input type="checkbox"/> Employee <input type="checkbox"/> Graduate Assistant		CHANGE TO BE EFFECTIVE for the Tax Year _____		
CURRENT HEALTH PLAN _____				

2. TAX STATUS CHANGE				
Last Name	First	Middle (Prev	ious Name)	Tax Dependent? (Y/N)
Spouse/Domestic Partner				
Dependent				
Dependent				
Dependent				
Dependent				

3. SIGNATURE	
<input type="checkbox"/> I wish to change the tax status of a dependent. I have read, understand, and agree to the Terms and Conditions accompanying this form.	
Reason for change _____	
Under the penalties of perjury, I declare that I have examined this Dependent Tax Status Change Form and to the best of my knowledge and belief, all statements and answers are true, correct, and complete. (This form is not valid unless you sign it.)	
SIGN HERE & Return to Employer ➔	Date Signed (MM/DD/YYYY) _____ Applicant Signature _____

4. EMPLOYER COMPLETES			
Date Application Received by Employer (MM/DD/YYYY)	Payroll Representative Signature	Telephone ()	
DEN TAX FIELD UPDATED	ETF TAX STATUS UPDATED	ADJUSTMENT/REFUND REQUESTED	PROCESSED BY/DATE/PHONE

COPY AND DISTRIBUTE: EMPLOYEE FILE UWSC Employee should retain a copy for her/his records.