



Declaration of Tax Status

This form is used to declare the tax status of dependent child(ren) for whom you are the court-appointed legal guardian, AND/OR of a Second Domiciled Adult and his/her child(ren), if you enroll any such individual in health benefits.

Please choose one:

- Dependent child(ren) for whom you are the court-appointed legal guardian
- Second Domiciled Adult and/or Child(ren) of your SDA
- Tax Status Change Only

Important: It can be complicated to determine whether an individual satisfies the definition of a tax dependent for health plan coverage purposes under the Internal Revenue Code. You may wish to consult a tax professional for advice on your personal situation before you declare that an individual is your tax dependent for health plan coverage purposes under the Internal Revenue Code.

A child qualifies for tax-favored benefits if he or she is a citizen or national of the United States, or is a legal resident of the United States, Mexico or Canada, and if he or she meets the definition of Qualifying Child or Qualifying Relative as follows:

1. *Qualifying Child – The child must meet all of the following:*
 - a. Is your child or step child (by blood or adoption), foster child, sibling or step sibling, or a descendant of such individual.
 - b. Is under age 19, or under age 27 and a full-time student, on the last day of the tax year, or is any age if totally and permanently disabled.
 - c. Does not provide over one-half of his or her own support.
 - d. Lives with you for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
2. *Qualifying Relative – The individual must meet all of the following:*
 - a. Is related to you or lives with you all year as a member of your household.
 - b. Receives more than one-half of his or her support from you.
 - c. Is not your “qualifying child” or the “qualifying child” of any other taxpayer.

An unrelated SDA is eligible for tax-favored health coverage only if he or she meets all of the following:

1. Is a citizen or national of the United States, or is a legal resident of the United States, Mexico or Canada.
2. Lives with you all year as a member of your household, except for temporary reasons such as vacation, military service, or education.
3. Receives more than one-half of his or her support from you.
4. Is not anyone else’s “qualifying child” dependent.

In addition, if you can claim a federal tax exemption for your Second Domiciled Adult (and/or his or her children), or for a child for whom you are legal guardian, then he or she is eligible for tax-favored health coverage.

The rules for determining support are complicated and are more involved than just determining the “primary breadwinner.” Refer to IRS Publication 17 “Your Federal Income Tax” for more information.

Continue to next page to complete the form.



Status (Federal)

List the individuals you wish to enroll for DePaul benefits and indicate whether you declare them to be eligible for federally tax-favored health coverage as defined on the previous page.

Child(ren) for Whom You Are Legal Guardian

Name(s)	Eligible for Tax-favored Coverage?	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SDA and SDA's child(ren)

Name(s)	Eligible for Tax-favored Coverage?	
Adult SDA:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SDA's Child:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SDA's Child:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SDA's Child:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SDA's Child:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I understand that if I do not declare individuals to be eligible for tax-favored health coverage, I will be subject to all applicable federal, state, local and payroll taxes for his/her/their benefits, and I am not permitted to use my flexible spending account for their un-reimbursed expenses. I agree to notify DePaul immediately of any changes in the tax statuses of my enrolled dependents. I understand that if I had previously certified my dependent children or Second Domiciled Adult and/or his or her children as eligible for tax-favored health coverage, I may be liable for taxes in the event that their tax statuses change.

(Name of Employee)

(Signature of Employee)

(Employee ID Number)

(Date)

HR representative signature _____

Date Processed _____