F-99946 Pts. 1-3; glueline @ top

JOHNS HOPKINS UNIVERSITY

Johns Hopkins Student Health Program

Benefits Election Form

For Office Use Only

Marriage Affidavit _____

Coverage Effective Date ____/____/____

Premium Effective Date ____/____/____

Department _____

Division Code _____

❒ MEDICINE ❒ PUBLIC HEALTH ❒ ECHO ❒ IMAGING
❒ SHERIDAN ❒ NURSING ❒ EDUCATION ❒ ENGINEERING
❒ ARTS & SCIENCES ❒ BERMAN INSTITUTE

A. TYPE OF REQUEST:

❒ New Enrollment ❒ Change of Coverage ❒ Change of Information ❒ Termination

B. GENERAL INFORMATION: (Please Complete All Lines)

Last Name	First Name	Middle Initial	Date of Birth / /
Number and Street			Home Telephone No. ( )
City	State		Zip Code
Sex: ❒ Male ❒ Female	Date of Appointment / /		Your Social Security No. — —

C. OTHER COVERAGE: DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH COVERAGE? ❒ YES ❒ NO

IF YES, IS COVERAGE ❒ INDIVIDUAL ❒ P/C ❒ H/W ❒ FAMILY

IF YES,
NAME OF HEALTH INSURANCE CARRIER: _____ POLICY NUMBER: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____ EFFECTIVE DATE OF COVERAGE: _____ TERMINATION DATE OF COVERAGE: _____

FAMILY MEMBERS COVERED AND RELATIONSHIP: _____

D. TYPE OF COVERAGE SELECTED: (check one)

❒ Individual ❒ Parent/Child ❒ *Husband/Wife ❒ * Family

Same Sex Domestic Partner:
❒ * Two Party ❒ * Two Party + Dependent

E. DEPENDENTS:

Last Name	First Name	Birth Date Month / Day / Year	Social Security Number	Sex M/F	Relationship			
					Spouse	Son	Daughter	Other

F. SIGNATURE

- I hereby apply for myself and any dependents listed on this Election Form for the coverage indicated. I understand that the completion of the Affidavit of Marriage/Domestic Partnership form is required before processing applications for coverages indicated with an *.
- If accepted, I understand that coverage is subject to the exclusions and all other provisions contained in the benefit plan.
- I agree to pay the current and future premiums for these benefits as long as I remain in my present status and authorize deductions (if applicable) from my pay. I understand that I am responsible for any portion of my student health plan premium that the University is not responsible for paying.
- I have carefully read this Election Form. The statements and representations made are true and complete.

Date ____/____/____ Signature _____

Remarks:

Original / Business Office Copy 2 / EHP Copy 3 / Registrar's Office

JOHNS HOPKINS UNIVERSITY

Homewood Postdoctoral Fellow
Affidavit of Marriage/Same-Sex Domestic Partnership

I, _____ SSN _____-_____-_____ certify that
Name and SSN of Postdoctoral Fellow (print)

Complete <u>either</u> A or B:

A.
I, and _____SSN _____-_____-_____were legally married on __/____/____,
Name and SSN of Spouse (print)

-OR-

B.
I, and _____SSN _____-_____-_____became same-sex domestic
Name and SSN of Same-sex Domestic Partner (print)
partners on ___/___ /____,

and we certify the following to be true:

1. We are committed as a family in a long-term relationship of indefinite duration and are socially, emotionally, and financially interdependent with each other in an exclusive mutual financial obligations; and
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 and our relationship does not violate state or local law; and
3. we agree to notify Johns Hopkins University if there is any change in our status of marriage or domestic partnership as certified in this statement within thirty days of that change by filing a Marriage/Same-sex Domestic Partnership Termination Form; and
4. we were competent to consent to contract when our marriage or domestic partnership began; and
5. we understand that any marriage or domestic partnership recognized by the University based on this affidavit will be treated as terminated for benefits purposes upon the death of my spouse/domestic partner or on the date indicated in a Marriage/Same-sex Domestic Partnership Termination Form submission (or, if earlier, on the date of divorce or legal separation of a legal marriage); and
6. we understand that benefits provided by Johns Hopkins University for a domestic partner or a child of a domestic partner generally will be subject to federal (and possibly state) income tax withholding and also to Social Security and Medicare taxes based on the fair market value of those benefits and any employee contributions for coverage for those benefits must be made on an after-tax basis unless the postdoctoral fellow signs the statement at the end of this Affidavit to certify that the partner or child qualifies as a Section 152 Dependent (as described later in this Affidavit) of the postdoctoral fellow for tax purposes; and
7. we understand that this information will be held confidential but is subject to disclosure for administrative purposes, as required by law or upon our express written authorization; and
8. we understand that any person's eligibility for benefits is subject to auditing by Johns Hopkins University and its agents for verification purposes; and
9. we understand that legal implications under state and/or federal law may exist due to the declaration of responsibility for our common welfare; and
10. we understand that if we make a false statement or misrepresentation on this Affidavit of Marriage/Same-sex Domestic Partnership, the University reserves the right to take any and all actions necessary to deny benefits or to recover amounts paid for benefits to which a person was not entitled, as well as any expenses or attorney fees incurred by the University in an attempt to recover such amounts and that any false statements on this Affidavit may lead to other disciplinary action, up to and including termination of employment, and

11. we understand that completing this Affidavit is only one requirement for certain benefits and that all eligibility requirements and other provisions of all benefit plans as well as policy provisions of University programs will also apply.

Postdoctoral Fellow's Signature: _____Date: ___/____/____

Postdoctoral Fellow's Name Printed: _____

Spouse/Same-Sex Domestic Partner's Signature: _____ Date: ___/____/____

Spouse/Same-Sex Domestic Partner's Name Printed: _____

NOTE: You should review the definition below and sign the statement below if you intend to elect any type of coverage for your domestic partner or any child of your domestic partner, if you conclude that your partner or your partner's child is your dependent for tax purposes.

Internal Revenue Code Section 152 Definition of Dependent
For purposes of the University's benefits, a *domestic partner generally will be your dependent under Internal Revenue Code section 152 (referred to as "Section 152 Dependent" in this Affidavit) only if you provide over one-half of your partner's financial support and your partner Jives with you during the entire tax year. A child of your domestic partner who is not your adopted or biological child generally will qualify as your Section 152 Dependent for purposes of these benefits for* a *tax year only if (1} you provide over one-half of the child's support, (2) the child Jives with you and (3) neither your domestic partner nor any other taxpayer claims the child as a dependent for federal tax purposes. Additional rules and restrictions may apply. You should consult with* a *tax adviser if you have any question about whether your domestic partner or* a *child qualifies as your dependent for tax purposes.*

If your domestic partner or any child* of *a domestic partner qualifies as a Section 152 Dependent for purposes* of *medical, dental, and personal accident benefits and you do not want to be taxed on the value* of *any of those benefits provided to your domestic partner or a child* of *a domestic partner, you must complete the following:

By signing below, I certify that I have reviewed the requirements for a domestic partner or a child of a domestic partner to be treated as my Section 152 Dependent for purposes of the Plan and that the following person or persons *(check appropriate box or boxes):*

- ☐ my domestic partner
- ☐ the following child or children of my domestic partner *(list by name):*

_____
_____
_____

qualify as my Section 152 Dependents for purposes of the Plan's health or dental benefits. **I** agree to promptly inform the University if any person indicated above ceases to qualify as my Section 152 Dependent while covered under any of these benefits.

Postdoctoral Fellow's Signature: _____ Date: ___/____/____

RETURN FORM TO:
KSAS/WSE Office of Human Resources,
6th Floor Wyman Park, Suite 650