Aurora Public Schools
Group Health Plan
Certification of Domestic Partner Status

I hereby certify that the statements below are true and correct.

1. _____ is my domestic partner on the date of this Certification.

2. My domestic partner has the following child(ren) which I intend to enroll in the group health plan *[list the child(ren)'s name(s) on the line below]*:
_____.

3. I have read the notice entitled "Summary of Tax Treatment of Health Coverage Provided for Domestic Partners," and I understand the requirements for qualifying another person as my federal tax dependent for health coverage purposes.

4. My domestic partner *[place your initials next to the line that applies to you]:*
_____ qualifies as my federal tax dependent for health coverage purposes in the current tax year.
or
_____ does not qualify as my federal tax dependent for health coverage purposes in the current tax year.

5. My domestic partner's child(ren) listed above *[place your initials next to the line that applies to you]:*
_____ qualifies/qualify as my federal tax dependent for health coverage purposes in the current tax year.
or
_____ does not/do not qualify as my federal tax dependent for health coverage purposes in the current tax year.

6. I agree to notify the Benefits Office of the Aurora Public Schools group health plan in writing as soon as possible if there is any change in status regarding my above-mentioned tax dependent(s) for health coverage purposes, including any change that may occur mid-year. I understand that any change in such status may result in the retroactive application of taxes to amounts previously paid for health coverage during the year.

7. I understand that on the basis of the above statements, the District will decide whether to treat the above person(s) as my tax dependent(s) for all federal income and employment tax purposes, and that if I fail to complete this Certification or any recertification requested by the District, then the District will assume that the person(s) does/do not qualify as my federal tax dependent(s) for health coverage purposes.

8. I agree to reimburse the District for any and all taxes, penalties, or other losses (including reasonable attorneys' fees) that the District may incur as a result of its reliance on this Certification if it is untrue or incorrect in any respect, or if I fail to provide the notice required by paragraph 6 above.

_____
Signature

_____ _____
Type or Print Name Date