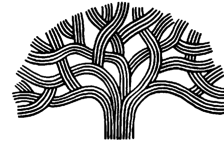
CITY OF OAKLAND 

150 FRANK H. OGAWA PLAZA, 3RD FLOOR • OAKLAND, CALIFORNIA 94612

Department of Human Resources Management

(510) 238-3307
FAX (510) 238-7129
TDD (510) 839-6451

January 20, 2012

Re: <u>Imputed Income for Domestic Partner and/or their Dependents Health Coverage</u>

The City of Oakland extends medical, dental and vision benefits coverage to full-time and permanent part time employees and their registered domestic partners and eligible dependent child(ren). Our records indicate that you and your Registered Domestic Partner and/or their dependent child(ren) are enrolled in the City's sponsored health plans.

Federal law does not recognize Domestic Partners as dependents unless the employee contributes over half of the financial support for the individual(s) being covered under the employee's benefit plan AND the covered individuals meet the definition of "dependent" under Code Section 152. *Please see the definition of "qualifying relative" on the reverse side of this notice.*

The value of any health coverage an employer pays on behalf of the domestic partner and/or their dependent(s) who do not meet the definition of "dependent" as define on the reverse side of this notice must be reported as the imputed income for the employee and subject to federal income and employment taxes.

<u>The formula used to calculate the imputed income (taxable portion) is as follows:</u>

<u>Example:</u>
Employee plus 3 dependents (domestic partner & 2 dependent children)
Kaiser Family rate = $1,587.14 per month (fully paid by the City)
To calculate Imputed Income value:

1. $1,587.14 (family rate) divided by 4 (total covered) = $396.79 (premium value for each covered person);
2. $396.79 multiplied by 3 (total number of dependents; *cost for employee is excluded*)
3. $1,587.14 (total premium) minus $1,190.37 ($396.79 for each 3 dependents)
4. Imputed income value = $1,190.37 per month

The same formula applies for dental and vision coverage paid for by the City.

In some cases benefit contributions toward coverage for the domestic partners and/or their dependent child(ren) may be exempt from imputed income if the employee can

(*continued on back of page*)

certify that he/she she resides in the same household and contributes over half of the dependent(s) financial support during the tax year.

If you meet the exemption criteria for imputed income, please complete the attached Declaration of Dependency in Support of Non-Taxability of Benefits by February 1, 2012 and return it to the address indicated. If the form is not received by February 1, 2012, the imputed income value for domestic partner dependent coverage will be applied if your domestic partner and/or their dependent child(ren) are enrolled in these benefits.

Please mail the form to:

City of Oakland
Department of Human Resource Management
150 Frank Ogawa Plaza, 3rd Floor
Oakland, CA 94612

Attn: DENISE CARTER

Should you have any questions regarding imputed income, please visit the IRS website at www.irs.gov, or email Denise Carter at dcarter@oaklandnet.com

Very truly yours,

Yvonne S. Hudson-Harmon
Human Resources Manager, Retirement and Benefits

Enclosure: Declaration of Dependency in Support of Non-Taxability of Benefits

DEPENDENT STATUS

The federal tax code defines a “qualifying relative” as someone with one of the following relationships to an individual:

1. a child or a descendant of a child
2. a brother, sister, stepbrother or stepsister
3. the father or mother, or an ancestor of either
4. a stepfather or stepmother
5. a son or daughter of a brother or sister of the taxpayer
6. a brother or sister of the father or mother of the taxpayer
7. a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law
8. an individual (other than an individual who at any time during the taxable year was the spouse of the taxpayer) who, for the taxable year of the taxpayer, has the same principal resident as the taxpayer and is a member of the taxpayer’s household.

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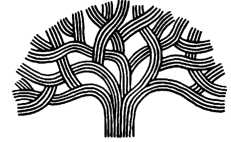

150 FRANK H.OGAWA PLAZA, 3RD FLOOR • OAKLAND, CALIFORNIA 94612-2021

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Declaration of Dependency in Support of Non-Taxability of Benefits

I, ____ declare that:
CLEARLY Print Employee Name (Last, First, MI)

A. My Social Security Number is ________________________________,
Print LAST 4 DIGITS of Employee Social Security

B. I am requesting the City of Oakland provide insurance coverage (medical and/or dental and/or vision) for myself and the following person(s) (if more space needed, list additional person(s) on a second page):

Name (Last, First, MI)	Birth Date	Sex	Relationship (*indicate on of the following: domestic partner, natural child of employee, child of domestic partner, economically dependant child, mentally or physically disabled child.)*
1.			
2.			
3.			
4.			

C. I have verified that each of the above named person(s) in declaration #B is entitled to be claimed as a dependent on my annual federal income tax return.

D. Each of the above named person(s) in declaration #B resides with me as a member of my household.

E. I am responsible for fifty percent (50%) or more of the financial support and maintenance for each of the above named person(s) in declaration #B.

F. I understand that I am responsible for the tax consequences (including interest and penalties) should there be any misstatements made in this declaration or, even in the absence of a misstatement, should the United States Internal Revenue Service or the State of California Franchise Tax Board so determine that the benefits I am receiving in insurance coverage for myself and/or the person(s) listed above in declaration #B are otherwise taxable income.

G. I will notify the City of Oakland Benefits Office in writing within thirty (30) days of any change related to the dependent status of any of the above named individuals in declaration #B.

H. I agree to provide any supporting documentation when requested by the Benefits office so long as I have my domestic partner or eligible dependents enrolled in one or more of the City of Oakland's insurance plans.

I declare, under penalty of perjury, that the foregoing declarations are true and correct.

Executed this ____________ day of ____________________ in the Year ________ at ______________________, California.
Day **Month** **Year** **City, Town**

____
Employee Signature