NINTH JUDICIAL COURT EMPLOYEES ASSOCIATION WELFARE FUND
ENROLLMENT FORM

PLEASE COMPLETE, SIGN AND RETURN TO:
NJDCEA WELFARE FUND.
222 BLOOMINGDALE ROAD #101
WHITE PLAINS, NY 10605 PHONE 1-914-949-8529

SECTION I MEMBER INFORMATION

SOCIAL SECURITY NUMBER				DATE OF BIRTH
☐☐☐-☐☐-☐☐☐☐				☐☐/☐☐/☐☐

LAST NAME	FIRST NAME	MI	PHONE	EMAIL

ADDRESS	APT NO.	CITY	STATE	ZIP

GENDER: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED

EMPLOYMENT IN THE NYS-OCA SYSTEM COMM3NCE DATE_____ WORK LOCATION ☐ WESTCHER ☐ ROCKLAND

EMPLOYMENT IN WESTCHESTER/ROCKLANDS COURT COMMENCE DATE_____

JOB LOCATON ☐ COMBINED COURT ☐ LAW LIBRARY ☐ FAMILY COURT ☐ COMMISSIONER OF JURORS ☐ SURROGATES

SECTION II SPOUSE INFORMATION-PLEASE ATTACH MARRIAGE CERTIFICATE

FIRST NAME	LAST NAME	MI	DATE OF BIRTH	SOC SEC NO.

IS SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES EMPLOYER NAME:_____

DOES THIS EMPLOYER PROVIDE A DENTAL PROGRAM? ☐ YES ☐ NO OPTICAL BENEFIT PROGRAM? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE NAME AND ADDRESS OF
INSURANCE COMPANY/ PLAN ADMINISTRATOR:

SECTION III DEPENDENT CHILD INFORMATION - PLEASE ATTACH BIRTH CERTIFICATE

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐

SECTION IV MEMBER SIGNATURE

I HEREBY CERTIFY THAT ALL THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A DENIAL OR SUSPENSION OF BENEFITS. IN ADDITION, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

MEMBER'S SIGNATURE:_____ DATE:_____/_____/_____

FOR OFFICE USE ONLY

VERIFICATION BY:_____ DATE:____/____/____ ELIGIBILITY START DATE:____/____/____

Ninth Judicial District Court Employees Association
Membership Application

I, _____, residing at
(Full Name)

_____,
(Full Street Address)

working in the Ninth Judicial District, in _____ County, in the following

title, _____,

do hereby

Apply for membership in the Ninth Judicial District Court Employees Association. **Please Hand Deliver to a Union Director/Officer or E-Mail to the President of the Association:**

president@njdcea.org

I understand that **$12.00** will be withdrawn from my bi-weekly paycheck for membership dues as provided by the Constitution and By-Laws of the Association. This application shall serve as my authorization to the Association to represent me for collective bargaining purposes before the Office of Court Administration or any other city or state agency before which such representation may be required. I do hereby expressly revoke any authorization for collective bargaining on my behalf either expressly given or which may be implied from my membership in any other employee group.

Date: _____ Signature _____

Title: _____ Agency Code: G9

Date Employed: _____ Salary Grade: _____

Court Phone: _____ Court E-Mail: _____

Mobile Phone: _____ Home E-Mail: _____

---

office use only: date:_____ entered by_____

Form: 12/2020

Guardian

Group Insurance Enrollment Form

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: Ninth Judicial District Court Employees Association

Group Plan Number: 00582041

Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX Initial Enrollment Re-Enrollment Add Employee/Dependents Drop/Refuse Coverage Information Change Increase Amount Family Status Change

Class: n/a Division: n/a Subtotal Code: n/a (Please obtain this from your Employer)

About You:

First, MI, Last Name:

Social Security Number
XXXXXXXXXXXXXXXXX
___ ___ ___-___ ___-___ ___ ___ ___

Address | City | State | Zip

Gender: M F Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) -

Email Address:

Are you married or do you have a spouse? Yes No Date of marriage/union: ____-____-_____

Do you have children or other dependents? Yes No Placement date of adopted child: ____-____-_____

About Your Job:

Job Title:

Work Status:
Active Retired Cobra/State Continuation
Hours worked per week: _____

Date of full time hire: _____ - _____ - _____

Annual Salary: $_____

Basic Life Coverage:

Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only
☑ $50,000
The Guarantee Issue Amount is $50,000.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

Primary Beneficiaries:

Name:_____ Social Security Number:___-___-_____%___

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

Name:_____ Social Security Number:___-___-_____%___

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

Contingent Beneficiary:_____ Social Security Number: ___-___-_____

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

If this Basic Life policy is intended to replace your existing life insurance policy under your current employer, provide the amount of the previous policy $___n/a___

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Dec 03, 2020

Signature

I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.

I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.

I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.

I hereby apply for the group benefit(s) that I have chosen above.

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

I agree that my [employer] or my employer's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.

I state that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil Penalties, or denial of insurance benefits (Does not apply to Life Insurance).

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount is associated with the accelerated death benefits. A fee of up to $250.00 will be required for the administrative cost of evaluating and processing Your application for this benefit.

The Policy permits the group Policyholder to change, reduce, restrict or terminate Your rights or benefits under the Policy without Your consent; and b) such change, reduction, restriction or termination may occur at a time when Your health status has changed and may affect Your ability to procure individual coverage.
The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

The following section applies to these coverage(s):Basic Life

READ YOUR CERTIFICATE CAREFULLY,CERTAIN WAR RISKS ARE NOT ASSUMED.IN CASE OF ANY DOUBT,CONTACT YOUR COMPANY FOR FURTHER EXPLANATION.

The following section applies to these coverage(s): Accident Coverage, Specified Disease Coverage, Hospital Indemnity Coverage:

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

If you have questions about the benefits provided by this coverage, please contact us at 1-888-541-7846.

By my signature below, I affirmatively consent to receive electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I understand that I may change my election by providing Guardian 30 days prior written notice. I am opting out of receiving electronic copies of applicable insurance related documents and I understand such documents will be mailed to me at the address provided.

SIGNATURE OF EMPLOYEE X _____ DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Administrative Services Only, Inc Authorization Form
Health Insurance Portability and Accountability Act (HIPAA)

303 Merrick Road, Suite 300, Lynbrook, NY 11563
Tel: (516) 396-5500 / (800) 537-1238 (outside NY) Fax: (516) 396-5553

I. Participant Information (Please Print)

LAST NAME	FIRST NAME	SOCIAL SECURITY #:	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	HOME TELEPHONE	WORK TELEPHONE	
EMPLOYER			

II. Specific person/organization (or class of persons) authorized to receive and use the information

NAME	RELATION TO PARTICIPANT	NAME	RELATION TO PARTICIPANT
1.		2.	
3.		4.	
5.		6.	

III. Specific description of the information: (dental claim information, etc.)

_____

_____

_____

_____

_____

_____

_____

IV. Right to revoke

I understand that I have the right to revoke this authorization at any time by notifying ASO in writing at 303 Merrick Road, Suite 300, Lynbrook, NY 11563. I understand that the revocation is only effective after it is received and logged by ASO. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization.

Signature_____ Date__ _____

If a Personal Representative executes this form, that Representative warrants that he or she has the authority to sign this form on the basis of: _____

NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND

APPLICATION FOR DOMESTIC PARTNER COVERAGE

1. Complete and Sign the **Application for Domestic Partner Coverage**. Please read each question carefully and print all required information. Be sure to answer all applicable questions. This will avoid delay in processing your application.
2. Complete and Sign the **Affidavit of Domestic Partners**
3. Complete and sign the **Declaration of Financial Interdependence**

Mail the completed application with proof of age for yourself and for your domestic partner along with the signed and executed affidavits to:

NJDCEA BENEFIT FUND
c/o Administrative Services Only, Inc.
303 Merrick Road, Suite 300,
Lynbrook NY 11563,

PERSONAL DATA

Participant Name:_____ Soc Sec No. ☐☐☐-☐☐-☐☐☐☐

Address:_____ City:_____ St_____ Zip:_____

Date of Birth: ☐☐/☐☐/☐☐☐☐ **(Attach proof of age)**

Telephone:_____

Are you legally married? ☐ Yes ☐ No

Name of Domestic Partner:_____

Date of Domestic Partner's Birth: ☐☐/☐☐/☐☐☐☐ **(Attach proof of age)**

Domestic Partner's Soc Sec No. ☐☐☐-☐☐-☐☐☐☐

If your domestic partnership terminates, you must notify the Fund Office within 31 days of such termination by filing Statement of Termination of Spousal Equivalency. This Statement affirms that the spousal equivalency status is terminated as of its date of execution and that you have mailed a copy of this statement to your domestic partner. After such termination you must wait at least 12 months before applying for domestic partner coverage, unless it is for the same domestic partner.

Coverage for your Domestic Partner begins the next Coverage Period after the Fund Office receives the Affidavit of Domestic Partner along with supporting information.

If you lose health coverage due to a reduction in hours, you may continue to self-pay the premiums for yourself and your domestic partner for a period of time under the Plan's COBRA rules. COBRA coverage is not available to your domestic partner upon your death or the termination of your relationship

_____ _____

Participant Signature **Date**

NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND

AFFIDAVIT OF DOMESTIC PARTNERS

I,_____, am the domestic partner of _____ and
Your Name Participant's Name

I,_____, am the domestic partner of _____
Participant's Name Your Name

We depose and declare as follows:

1. We are both at least 18 years of age and mentally competent to consent to contract;
2. We are each other's sole spousal equivalent and intend to remain so indefinitely;
3. We are not related by blood closer than which would otherwise prohibit legal marriage in the state in which we legally reside;
4. We have been living together on a continuous basis for twelve months prior to the date of this affidavit and intend to live together indefinitely;
5. We are committed to each other's common welfare and are mutually responsible for basic living expenses; and
6. Please check which applies

   ☐ We have registered as domestic partners in our municipality (and we have attached a copy of our registration).

   Or

   ☐ We live in _____, _____ where there is no domestic partner registry
   City State
   (and we have attached a completed Declaration of Financial Independence).

7. We understand that unless we present proof that the domestic partner is financially dependent on the participant within the meaning of the Internal Revenue Code Section 152, the benefits will be taxable as wages (subject to withholding, FICA and FUTA) in the amount of the value of such coverage.
   We agree to notify the Ninth Judicial District Court Employees Association Benefit Fund if there is any change in the information attested to in this affidavit.

_____ _____
Print Name Print Name

_____ _____
Signature Signature

On this _____ day of _____,_____,

came_____ and _____ to me known to be the persons described above, who executed the foregoing statement before me under oath.

_____ _____
Notary Public Date

NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND

DECLARATION OF FINANCIAL INTERDEPENDENCE

We, the undersigned domestic partners, are financially interdependent.

We submit the following two (2) items of proof that may provide evidence sufficient to show financial interdependence:

☐ **We jointly appear as co-tenants on the lease for our residence.**
(Lease with both names)

☐ **We jointly own our residence.**
(Deed or other sale/transfer document with both names, mortgage naming the participant and Domestic Partner as joint obligors for a common resident)

☐ **We have a joint bank account, brokerage or investment account**
(Statement with both names, Check with both names, Passbook with both names, brokerage account document with both names, investment account with both names)

☐ **We keep a common household**
(utility bills in both names for a common residence (e.g., telephone bills, electric bills, joint public assistance budget, etc.))

☐ **We have executed will(s) naming one of us as the primary beneficiary of the other.**
(Copy of will or wills, with each party naming the other as beneficiary and/or executor)

☐ **At least one of us has designated the other as the primary beneficiary under a retirement benefit account.**
(Copy of beneficiary designation form with one party designating the other as beneficiary)

☐ **At least one of us has designated the other as the primary beneficiary under a Life Insurance Policy**
(Copy of beneficiary designation form with one party naming the other as beneficiary)

The Trustees have the discretion to consider any other documents as satisfactory evidence of financial independence. Please set forth below a description of such documents and attach copies.

☐ **Other item of proof as is sufficient to establish economic interdependence under the circumstances of the particular case (specify)**

All determinations of whether a particular item is acceptable to prove financial independence shall be made by the Plan Administrator, in its sole and absolute discretion.

_____ _____
Print Name Print Name

_____ _____
Signature Signature

On this _____ day of _____,_____,

came_____ and _____ to me known to be the persons described above, who executed the foregoing statement before me under oath.

_____ _____
Notary Public Date

NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND

c/o **ADMINISTRATIVE SERVICES ONLY, INC.**
303 MERRICK ROAD, SUITE 300
LYNBROOK, NY 11563-9010
TEL: 1-877-999-3555 FAX: 516-396-5593

DOMESTIC PARTNER COVERAGE

1. Definition of Domestic Partners.

NJDCEA BENEFIT FUND defines domestic partners as follows:

Two unmarried adults (both of whom are 18 years or older), neither of whom is married or legally separated who:

a) have resided with each other for twelve months prior to the application for benefits and who intend to live continuously with each other indefinitely;
b) are not related by blood closer than the law would permit by marriage;
c) are financially dependent on each other;
d) have an exclusive close and committed relationship with each other; and
e) have not terminated the domestic partnership.

2. Procedures for Verifying Domestic Partner Status.

A participant who seeks domestic partner coverage will be required to submit a notarized "Affidavit of Domestic Partnership" attesting to the domestic partner status and a notarized "Declaration of Financial Interdependence" along with two items of proof of financial interdependence (such as joint lease or mortgage or a joint bank account). (The Affidavit and Declaration are attached.)

Those who live in municipalities offering a domestic partner registry (such as New York City and San Francisco) will be required to show proof that they have registered as domestic partners.

Persons who fraudulently, wrongfully (or negligently) obtain coverage for persons who are not entitled to such coverage, or who fail to timely notify the Fund Manager of the termination of a domestic partnership, may be subject to civil action.

3. Domestic Partner Coverage.

Domestic Partners of participants are eligible for family health coverage on the same basis as current dependent coverage.

4. COBRA

If you lose health coverage due to a reduction in hours, you may continue to self-pay the premiums for yourself and your domestic partner for a period of time under the Plan's COBRA rules. COBRA coverage is not available to your domestic partner upon your death or the termination of your relationship.

5. Taxation.

If the Employer pays for domestic partner coverage, this benefit is taxable as wages unless the participant's domestic partner is financially dependent on the participant.

a) Financially Dependent Domestic Partners

If the Participant presents proof satisfactory to the Trustees that his or her domestic partner is a financial dependent within the meaning of Section 152 of the Internal Revenue Code, health benefits to such partners are not taxable. Section 152 defines a financial dependent as one who resides with you and for whom you provide more than 50% support. Adequate proof shall ordinarily mean copies of tax returns showing the partner as a financial dependent and a supporting affidavit.

b) Non-Dependent Domestic Partners

Except as provided above for financially dependent domestic partners, health insurance paid by the Employer for a participant's domestic partner is taxable as wages in the amount of the fair market value of the insurance. Fair market value shall ordinarily mean the difference between the family and individual premium paid on the individual's behalf. Such amount will be subject to federal and state taxes, including withholding, social security and Medicare (FICA), and unemployment (FUTA). Such taxes must be prepaid by the participant quarterly. The Fund Office will provide participants a schedule to determine the appropriate taxes.

c) Self-pay Domestic Partner Coverage

If the participant pays the cost of domestic partner coverage, the benefit is not taxable.

6. Modification and Interpretation.

The Trustees reserve the right to amend or modify the eligibility requirements for domestic partner coverage and to amend, modify or terminate domestic partner coverage at any time for any reason. The Trustees reserve the right to interpret all plan documents concerning domestic partner coverage and to interpret the requirements for and extent of such coverage.

NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION
Welfare Fund
222 Bloomingdale Road #101
White Plains, NY 10605

914-949-8529

AFFIDAVIT OF DEPENDENCY

☐ **ACTIVE** ☐ **RETIREE (PLEASE CHECK ONE)**

_____ _____
Name of Member Member Social Security Number

To enable Ninth Judicial Court Employees Association Welfare Fund to determine the eligibility of the dependent child(ren) listed on my health benefits application, I state the following with respect to the child(ren) listed below:

RELATIONSHIP (check one)	**RESIDENCE** (check one)	**FINANCIAL SUPPORT**(check one)
☐ my child(ren) whose last name is different than mine. ☐ my stepchild(ren) ☐ Other_____ **Legal documentation required with affidavit**	☐ live(s) with me ☐ does not live with me **Legal documentation required with affidavit** ☐ Other_____ **Legal documentation required with affidavit**	☐ substantially dependent on me for support and maintenance ☐ not substantially dependent on me for support and maintenance

Name(s) of Child(ren) Please Print

Last Name	First Name	Date of Birth Month-date-year	Social Security #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I certify that the statement and information submitted above is correct.

_____ _____
Print Full Name Date

_____
Street Address City State Zip Code

_____ _____
Signature (must be the same name as printed above) Work Phone Number

State of _____ , County of _____

Sworn and subscribed before me on this ____ day of _____, 20___.

My Commission expires _____, _____.

Signature of the Notary Public _____

Official Title _____

Affidavit of Dependency Instructions

When must an Affidavit of Dependency be filed?

- For all stepchildren (must live with the employee), foster children, guardianship cases (including grandchildren, nieces, nephews, etc.) and wards when first listed for coverage.
- For newly adopted children when added to existing employee coverage.
- When the last name of the child differs from the last name of the employee**.**
- On parent-child(ren) contracts when the employee is divorced or single.

When must legal papers or court documentation be provided with the Affidavit of Dependency?

- For all adopted children, foster children, guardianship cases and wards.
- When the dependent child(ren) does (do) not live with the employee.

What constitutes acceptable documentation?

- A copy of the court decree that establishes the relationship between the employee and the dependent. In the case of a divorce, the copy need only contain those pages of the decree that identify the court, the employee and the dependent, the requirement for support, and the signature page.
- A copy of the custody agreement (the document placing the child in your home) from the placement agency.

What should I do with this form?

- If your situation requires an Affidavit of Dependency, complete the form and have your signature notarized.
- If legal documentation is required, attach a copy to the completed Affidavit.
- You must mail the original copies of all the required documentation to NJDCEA Welfare Fund at the address below:

NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION
Welfare Fund
222 Bloomingdale Road #101
White Plains, NY 10605

914-949-8529