State of Montana
Heath Care and Benefits Division

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Helena MT 59620-0130

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(406) 444-7462
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DECLARATION OF TAX STATUS

The State of Montana is required by the Internal Revenue Service to apply the proper tax treatment (before or after tax) to medical, dental, or vision benefits for which your spouse or domestic partner is currently enrolled. Therefore, it is important that you provide the tax status of your enrolled spouse or domestic partner. The qualification of your spouse or domestic partner for tax purposes does not affect their eligibility for the medical, dental, or vision plans, but does impact the tax treatment of that coverage. A flowchart is provided to assist you in determining and verifying the tax status of your spouse or domestic partner.

Insert below the name of your spouse or domestic partner who is enrolled in medical, dental, or vision benefits. Check one of the two boxes and return this form to the address above. ***If you do not check a box or respond, benefits payment contributions for your spouse or domestic partner will be taken on an after-tax basis, and the fair market value of the benefits provided by the State of Montana (i.e., those benefits funded through the state share) for your spouse or domestic partner will be added to your taxable income.*** The flowchart provides an overview of the tax rules; however, given the complexity of those rules, we recommend that you consult with your tax advisor regarding your specific circumstances.

Name of Spouse or Domestic Partner:_____

☐ Yes, this person is my spouse or domestic partner for tax purposes.

☐ No, this person is not my spouse or domestic partner for tax purposes.

If you have checked "No," benefits payment contributions for your spouse or domestic partner cannot be taken on a pretax basis, and the fair market value of the benefits provided by the State of Montana (*i.e.*, those benefits funded through the state share) for your spouse or domestic partner will be added to your taxable income.

I understand that the State of Montana is required to confirm whether my spouse or domestic partner meets the appropriate definition(s) for tax purposes for the medical, dental, and/or vision plans. I certify that the information that I have provided is true. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I agree to notify ***Health Care and Benefits Division*** *if there is any change in these circumstances within thirty (30) days of the change. I am aware that changes may impact the tax treatment of my coverage.*

_____ _____
Printed Name of Employee Social Security Number

_____ _____
Signature of Eligible Employee Date

ADMINISTRATIVE USE ONLY

System Entry Date_____ Entered By_____