



2027 Certification for Dependent Tax Status

I have read the information in this document, and I understand the requirements in the Internal Revenue Code for qualifying a domestic partner and/or a domestic partner's child or children as my federal tax dependent(s) for health coverage purposes. I understand that due to the potential impact of any imputed income, I should seek advice from a competent tax professional before certifying as to the tax status of covered individuals. I may wish to refer to www.irs.gov for information. For example, IRS worksheet [Publication 501](#) can be used for determining the support tests under Internal Revenue Code section 152.

The individual(s) listed below qualify as my federal tax dependent(s) for health coverage purposes for 2027:

Domestic partner's name: _____ Birth date _____ ☐ Yes ☐ No

List each child of a domestic partner to be certified as a tax dependent:

_____ Birth date _____ ☐ Yes ☐ No

_____ Birth date _____ ☐ Yes ☐ No

_____ Birth date _____ ☐ Yes ☐ No

_____ Birth date _____ ☐ Yes ☐ No

I agree to notify Pinellas County in writing within thirty one (31) days if there is a change in the status of any of the above individuals as my 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.

I understand that on the basis of the statements in this Certification, Pinellas County will decide whether to treat the above person(s) as my tax dependent(s) for healthcare purposes and that if I fail to complete this Certification or any recertification requested by Pinellas County, then Pinellas County will assume that the individual(s) do(es) not qualify as my federal tax dependent(s) for health coverage purposes.

I agree to reimburse Pinellas County for any and all taxes, penalties, or other losses (including reasonable attorneys' fees) that Pinellas County 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 above.

I hereby certify that the above statements are true and correct. Additionally, I acknowledge that knowingly making a false statement may subject me to disciplinary action, up to and including termination of employment, loss of benefits, an obligation to reimburse Pinellas County for any costs involved providing benefits coverage, and possible legal action.

Type or Print Name

Employee ID Number

Signature

Date

Submit this completed form and documents to Employee Benefits, Human Resources, Annex Building, 400 S. Ft. Harrison Ave., Clearwater, FL 33756, or fax to (727) 453-3573. Questions? Call Benefits at (727) 464-3367.