LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

PRINT

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Submit form to:
Online | lacers.org/secure-document-upload
Fax | (213) 473-7297 **Mail Stop** | 175
Mail | 977 N. Broadway, Los Angeles, CA 90012 -1728

CERTIFICATION OF DEPENDENT OR SURVIVOR STATUS FOR HEALTH COVERAGE – All Members

The Los Angeles City Employees' Retirement System (LACERS) Healthcare program offers coverage for retired employees, spouses (opposite or same-sex), domestic partners, children and Surviving Spouses/Domestic Partners. In order to ensure that LACERS is providing proper tax treatment of the medical subsidy, we must confirm whether your spouse, domestic partner, and/or child(ren) meet the definition of "spouse" or "dependent" under federal tax law. In addition, we must confirm which persons are Surviving Domestic Partners. If you have any questions regarding these definitions, please consult your tax advisor.

I understand that LACERS must confirm that my spouse, domestic partner and/or child(ren) meet the definition of "spouse" or "dependent" for tax purposes. I also understand that LACERS has a need to confirm the status of any person who is a Surviving Domestic Partner.

I certify that any individual for whom I have checked the box labeled "Yes" under Tax Dependent is my spouse as defined in Internal Revenue Code Section 7703, or is my tax dependent as defined in Internal Revenue Code Section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B)).

I certify that I am a (check one)
- ☐ Retired LACERS Member
- ☐ Surviving Spouse of a Retired LACERS Member
- ☐ Surviving Domestic Partner of a Retired LACERS Member

A portion of my health plan subsidy may cover the dependents listed: (Please Print)

1.
Dependent's Name[1] _____ **Dependent's social security #** _____
Relationship to self ☐ Spouse ☐ Domestic Partner ☐ Child
Is this person a Tax Dependent?[2] ☐ Yes ☐ No

2.
Dependent's Name[1] _____ **Dependent's social security #** _____
Relationship to self ☐ Spouse ☐ Domestic Partner ☐ Child
Is this person a Tax Dependent?[2] ☐ Yes ☐ No

3.
Dependent's Name[1] _____ **Dependent's social security #** _____
Relationship to self ☐ Spouse ☐ Domestic Partner ☐ Child
Is this person a Tax Dependent?[2] ☐ Yes ☐ No

4.
Dependent's Name[1] _____ **Dependent's social security #** _____
Relationship to self ☐ Spouse ☐ Domestic Partner ☐ Child
Is this person a Tax Dependent?[2] ☐ Yes ☐ No

1. The definition of a Dependent who is eligible to be included on your health plan differs from the definition of a Tax Dependent.
2. A spouse or child who is age 26 or younger for the entire tax year is automatically considered a tax dependent and medical coverage will not result in imputed income.

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By signing below, you are stating that:

I certify that the information I have listed above 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 understand if any of the information I have provided is false or misleading, it could result in actions, up to and including disenrollment from LACERS Retired Member Healthcare program. I agree to notify LACERS, at 800-779-8328, within 30 days of any change in these circumstances. I understand and agree that it is my responsibility to notify LACERS of changes in the tax status of any of my dependents.

Printed Name	**Signature**
Social Security Number	**Date**

ADA NOTICE

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.

DO NOT COMPLETE – FOR LACERS USE ONLY	
RECEIVED ON: DATE:_____	RECEIVED BY: PRINT NAME_____ SIGNATURE_____