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Los Alamos NATIONAL LABORATORY

Form 3028

Declaration of Legal Ward as Eligible Dependent

Return completed form to **LANL Benefits Office**:
Fax: 505-665-2156
Email: benefits@lanl.gov

Health Insurance Subscriber			
Last Name	First Name	Z Number	Social Security Number
Enrolled Dependent			
Last Name	First Name	Z Number	Social Security Number

You must complete one form for each enrolled dependent.

Declaration

I, a Triad Health Plan Subscriber, have the dependent listed above enrolled on my Triad-sponsored Health Insurance coverage and certify that he or she meets all the IRS criteria required, so the employer health premium contributions and/or deductions for this dependent will not result in imputed income, and may qualify for other favorable tax treatment in accordance with federal and state law.

By signing this declaration, I certify that I understand that all of the following requirements for this dependent will be met for the current tax year under Internal Revenue Code (IRC) Sections 105 and 152:

1. I will live together (share our principal abode) with this enrolled dependent for the full taxable year from January 1 to December 31, except for temporary absences for reasons such as vacation, military service, or education;
2. This enrolled dependent is a U.S. citizen, U.S. national, or a resident of the U.S., Canada or Mexico;
3. This enrolled dependent will receive more than half of his or her support from me during the current tax year.

- I agree that I will notify LANL Benefits Office within 31 days if there is any change in the circumstances attested to in this declaration, including any change that disqualifies this dependent as being eligible for LANL Health Plan benefits.
- I have read and understand the terms and conditions listed on the back of this declaration.
- I understand that falsely certifying such qualification could result in serious consequences, including termination from employment and/or legal action.
- I am aware that any change in family status may directly impact the calculation of my taxable income.
- I will submit this completed declaration to LANL Benefits Office by required deadlines to have my payroll deductions for health benefits changed during the next applicable pay period.

I declare under penalty of perjury that the foregoing is true and correct.

Signature/Date

Note: LANL employees are not authorized to give tax advice. Please consult with your personal tax advisor if you have any questions.

Note: This form shall be protected as LANL Employment Sensitive and/or LANL Employment Sensitive/PII when one or a combination of the following personal information items is revealed in a LANL record: education, salary, medical history, employment history, social security number, date and place of birth, or mother's maiden name.