Declaration of Tax Dependency

FOR DOMESTIC PARTNER AND/OR DOMESTIC PARTNER'S CHILD

Middlebury College

Send completed form to:
Middlebury College

Use this form to certify that your domestic partner and/or domestic partner's child(r en) enrolled in the medical, and/or dental plan is your tax dependent. If you, as the faculty or staff member have questions about tax dependency requirements, please see the attached information otherwise the College recommends that you contact the Internal Revenue Service and request a copy of IRS Publication 17 — Your Federal Income Tax for Individuals. This publication contains tax dependent information as well as tables to determine who is a tax qualified dependent. You may also consult your tax advisor.

Failure to certify your domestic partner and his/her children as legal dependents will generally result in the partial taxation of both the College and faculty/staff member health insurance premiums to the faculty/staff member.

PERSONAL INFORMATION

Name Of Faculty Or Staff Member *(Last, First, MI)*	Middlebury College ID:	U.S. Social Security Number

Street Address	City, State, Zip Code

Daytime Telephone Number	Email Address

TAX DECLARATION

I certify that I have, or will, declare my domestic partner and his/her children listed below on my Federal income tax return as a legal dependent under Sec. 152 of the Internal Revenue Code for tax year _____. I understand that falsely certifying such dependency could result in disciplinary action from the College, as well as potential charges of tax fraud. I further agree to notify the Human Resources Office immediately of any change in this tax status.

Domestic Partner			**Tax Dependent**	
NAME *(Last, First, MI)*	BIRTHDATE MO DY YR	SOCIAL SECURITY NUMBER	YES☐	NO☐

Domestic Partner's Child(ren)			**Tax Dependent**	
NAME *(Last, First, MI)*	BIRTHDATE MO DY YR	SOCIAL SECURITY NUMBER	YES☐	NO☐
NAME *(Last, First, MI)*	BIRTHDATE MO DY YR	SOCIAL SECURITY NUMBER	YES☐	NO☐
NAME *(Last, First, MI)*	BIRTHDATE MO DY YR	SOCIAL SECURITY NUMBER	YES☐	NO☐
NAME *(Last, First, MI)*	BIRTHDATE MO DY YR	SOCIAL SECURITY NUMBER	YES☐	NO☐

REQUIRED SIGNATURES

By my signature on this form, I affirm under penalty of perjury that the preceding statements are true and complete to the best of my knowledge. I further understand that any misrepresentation of these statements may result in serious consequences, including loss of benefits, discipline or appropriate legal actions. I understand that tax withholding changes related to this declaration will only be made on a *prospective* basis.

SIGNATURE OF FACULTY OR STAFF MEMBER	DATE

SIGNATURE OF DOMESTIC PARTNER	DATE