# Domestic Partner Benefits



You may elect Medical, Dental, Life/AD&D and/or Vision coverage for your same-sex or opposite-sex domestic partner. This memorandum gives you information about eligibility, enrollment procedures, costs and tax considerations:

Eligibility

You may enroll your same-sex or opposite-sex domestic partner in the Company's Medical, Dental, Life/AD&D and/or Vision Plans *provided that* both you and your partner meet the following criteria:

- You currently share a principal residence and have lived together continuously for at least 12 months
- Neither you nor your domestic partner are legally married to another person;
- Both of you are at least 18 years old;
- You are not related by blood;
- Neither you nor your domestic partner can be in a domestic partnership with anyone else; and,
- You're in a relationship that is intended to be both permanent and one in which each is the sole domestic partner of the other.

Enrollment Procedure

The Medical, Dental, Life/AD&D and Vision plans provide coverage for domestic partner. You can include your domestic partner's children on your plan, as well. You must enroll your domestic partner in the *same* plan(s) in which you are enrolled.

If you wish to enroll your eligible domestic partner and their children, if applicable, into your plans, you must choose employee + Domestic Partner or Employee + Domestic Partner + Child(ren),family coverage. **Your enrollment will not be approved until you provide the completed and notarized Affidavit of Domestic Partnership form along with the documents that are listed.**

If you enter into a new domestic partnership during the year, you may add your eligible domestic partner to your health care coverage within 30 days of your change in status, provided that you and your partner meet the eligibility criteria described above. *It is your responsibility to notify Human Resources within 30 days of the date of your change in status.* If notice is received beyond the 30 day period, you must wait until the next open enrollment period to add your domestic partner.

Costs

The cost for Medical, Dental, Life/AD&D and/or Vision coverage depends on which plan you choose and whether you elect employee + Domestic Partner or Employee + Domestic Partner + Child(ren), family coverage..

Under most circumstances, contributions for medical, dental and/or vision coverage for your domestic partner will be deducted from your pay on an *after-tax* basis and *will not be eligible for reimbursement* through your Flexible Spending Account (see below).

Tax Considerations

Generally, a domestic partner will *not* qualify as your dependent for federal income tax purposes. Under those circumstances, Internal Revenue Service (IRS) regulations require that the amount you pay toward health care coverage for your domestic partner must be deducted from your pay *after-tax*. The amount you pay toward coverage for yourself will continue to be deducted on a *pre-tax* basis.

In addition, IRS regulations require that you be taxed on the "value" of the benefits provided to your domestic partner. This value, known as *imputed income*, will be included in your W-2 earnings for the year, and you will have to pay taxes on this amount.

Unless a domestic partner qualifies as your dependent for federal income tax purposes, IRS regulations prohibit the amount you pay toward health insurance coverage for your domestic partner, as well as any co-payments, deductibles and other expenses for your domestic partner, from being reimbursed to you through your Flexible Spending Account.

Example of Tax Considerations

You enroll your domestic partner in the Company's health plan and your semi-monthly rate is $100. You would pay a semi-monthly pre-tax deduction of $50.00 for your medical coverage and a semi-monthly post-tax deduction $50.00 for your domestic partner. In addition, your imputed income would be the **difference** between the Company's contributions for employee only coverage (for you) and domestic partner's (and/or dependents) coverage. For example, if the Company's contribution to the Employee only plan is $400 per month and the Company's contribution to the Employee +1 plan is $800 per month you would pay imputed income on the $400 difference. This amount is added to your taxable income and taxed immediately.

Imputed income is separate from - and in addition to – your semi-monthly plan cost. The amount of your imputed income depends upon the plan in which you are enrolled and the salary tier of your coverage.

Imputed income is taxable – that is, it increases your taxable gross income for federal and state income taxes as well as for FICA (Social Security and Medicare). Your imputed income is reported on your annual Form W-2.

Based on IRS requirements, imputed income applies only to coverage of an eligible family member who is not your tax dependent.

**Imputed Income and Its Impact on Taxes**
**Estimate your imputed income and its impact – using the following worksheet.**

| | |
|---|---|
| 1. Your semi-monthly imputed income for medical coverage | |
| 2. Multiply line 1 by 24 pay periods for the total imputed income | = $ x24 |
| 3. Multiply line 2 by your federal income tax rate (28% or other) | Estimated federal income taxes on the imputed income<br>= $ x.28 |
| 4. Multiply line 3 by your state income tax rate. State tax is a percentage of your federal withholding | Estimated state income taxes on the imputed income<br>$ |
| 5. Multiply line 2 by 7.65% (your share of FICA) FICA taxes on the imputed income | x .0765<br>= $ |
| 6. Add lines 3 (federal taxes), 4 (state taxes), and 5 (FICA) | Total estimated taxes you must pay on the imputed income $ |

**When you Claim Your Domestic Partner or Your Partner's Child as Your IRS Tax Dependent**

Based on IRS requirements, imputed income applies only to coverage of an individual who is not your tax dependent. If your domestic partner (or your partner's child) qualifies as your tax dependent under Section 152 of the Internal Revenue Code, you should have no imputed income. To qualify, the domestic partner and partner's children must: a) receive over 50% of his or her support from you for the year; and, b) have as his or her principal abode your home for the entire year, and be a member of your household.

Contact the Benefits department if you will claim your domestic partner (or your partner's child) as your dependent.

The foregoing examples are for illustration only and may not reflect your actual circumstances. SS&C Technologies Inc. is not providing you with tax advice nor are we attempting to evaluate your particular situation. You are urged to consult your own tax advisor(s) concerning the federal and state income tax and employment tax ramification from your enrolling your domestic partner or your partner's children in one of SS&C Technologies Inc. medical plans.

**SS&C Technologies Inc.**
**Affidavit of Domestic Partnership**

I. AFFIDAVIT

We, _____and _____, each swear that
(employee-print name) (domestic partner-print name)

we are domestic partners in accordance with the following criteria:

II. STATUS

1. We affirm that this domestic partnership began on or about ___/___/___.
2. Neither of us is married to or legally separated from anyone else.
3. We are both at least eighteen (18) years of age and mentally competent to consent to contract.
4. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we reside.
5. We cohabit and reside together in the same residence.
6. We are jointly responsible for our common welfare and living expenses. Our interdependence is demonstrated by at least three of the following (please check appropriate items and provide proof of each item):

___ We have lived together continuously for 12 months*;
___ We have executed a domestic partnership agreement in a jurisdiction which authorizes such agreements;
___ Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
___ Common ownership of a motor vehicle
___ Driver's license listing a current common address or state or federal issued identification with current common address (e.g. voter registration card)
___ Proof of joint bank accounts or credit accounts
___ Proof of designation as the primary beneficiary for life insurance or retirement benefits, or beneficiary designation under a partner's will
___ Assignment of a durable property power or health care power of attorney

8. We are not in this relationship solely for the purpose of obtaining benefits coverage.
9. Neither of us has had a different domestic partner within the last 12 months from the date of the execution of this Affidavit (this condition does not apply if you had domestic partner who died).
10. We are aware that electing this coverage has tax implications. We are aware that we must pay income and FICA taxes on the additional employer contributions toward health coverage extended to our domestic partners.

*Signing the affidavit is proof for this item only.

III. DEPENDENT CHILDREN OF DOMESTIC PARTNER

We understand that dependent children of _____ (domestic partner- (print name) are eligible for coverage when they are:

- unmarried
- primarily dependent on the employee for support,
- living with the employee and domestic partner in a parent-child relationship, and
- meet the age/school and all eligibility requirements of the plan of benefits

- may be claimed by the employee or domestic partner as a dependent as defined in IRC section 152.

1.
Name of Child _____
Sex _____
Date of Birth _____

Dependent of: ____ Employee _____ Domestic Partner

2.
Name of Child _____
Sex _____
Date of Birth _____

Dependent of: ____ Employee _____ Domestic Partner

## IV. CHANGE IN DOMESTIC PARTNERSHIP

1. We have an obligation to notify SS&C Technologies Inc. Benefits Department if there are any changes in our status as domestic partners as attested in this Affidavit which would make the non-employee partner and/or any of his/her dependent children ineligible for the Company's health insurance program ((e.g., due to death of a partner, a change in residence of one partner, termination of the relationship, etc.). Such notification shall be provided within thirty (30) days of the change, by the filing a Declaration of Termination of Domestic Partnership form provided by the Company, which shall affirm that the domestic partner status is terminated, that health insurance will be terminated as of the end of the month of the date of termination of the domestic partner status, and that a copy of the Declaration of Termination has been mailed to the other party by the Company authorizing such action.

2. We understand that the termination of this coverage (obtained as a result of completion of this Affidavit) will be effective on the date the relationship ends as indicated on the Declaration of Termination of Domestic Partnership, providing coverage has not otherwise terminated due to standard policy provisions.

## V. ACKNOWLEDGEMENTS

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorney's fees and costs) due to any false statement contained in this Affidavit or for failure to notify SS&C Technologies Inc. of changed circumstances as required in Section IV above. I, the undersigned employee, further understand that falsification of information in this Affidavit, or failure to notify SS&C Technologies Inc., of changed circumstances pursuant to Section IV above, may lead to disciplinary action against me, up to and including discharge from employment.

2. We have provided the information in this affidavit for use by SS&C Technologies Inc. for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree that SS&C Technologies Inc. and its agents are not legally required to extend any such benefits.

We understand that this Affidavit may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this affidavit we should seek competent legal advice concerning such matters. We also represent that we have not relied on any

advice provided by the Company or Human Resources regarding any tax implications of participation in this benefit program.

We affirm, under penalty of perjury, that the statements in this Affidavit are true and correct. We understand that this form is not an application for health insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under the Company health insurance programs. Please note that termination of coverage for domestic partners does not qualify that person for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

_____ ___/___/___ ___-___-___ ___/___/___
Employee Signature DOB SS# Date

_____ ___/___/___ ___-___-___ ___/___/___
Domestic Partner Signature DOB SS# Date

Sworn to before me on ___/___/___
Date

_____
Notary Public

State of _____

County of _____