



Los Angeles Unified School District

Finance Division

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Los Angeles, CA 90017

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November 2025

Dear Employee:

Enclosed are the domestic partner health benefit enrollment materials. This packet includes the following:

- Domestic Partner Health Benefits Information Sheet
The information sheet answers a variety of questions related to the available health benefit coverage and the enrollment process. In addition, questions 8-9 address the District's obligation to report the value of the domestic partner coverage as "income" for the employee to the Internal Revenue Service.
- Declaration of Domestic Partnership (Form HB8)
The LAUSD Declaration of Domestic Partnership form describes the eligibility criteria and the required documentation for domestic partner coverage. This form, *which must be notarized*, requires you and your partner to attest to the fact that you meet all of the domestic partnership criteria and understand that the value of the coverage must be reported by the District to the Internal Revenue Service.
- LAUSD Request for Change of Dependent Status Form (Form HB7)/(HBA6)
This form is used to update the status of your dependent(s), including domestic partners. Please return it with the required documentation. Your domestic partner may be enrolled only in the same plans in which you are enrolled. If all the required documentation is received and approved by Benefits Administration by the end of the month, coverage will be effective on the first of the following month.

Optional Life Insurance

If you wish to purchase optional life insurance for your domestic partner, please contact Securian Financial at (866) 293-6047.

If you have any questions, please call Benefits Administration at (213) 241-4262 or you may email your questions to benefits@lausd.net.

Please be advised that District personnel cannot offer tax or legal advice; therefore, you may wish to consult an attorney and/or tax advisor regarding the possible impacts of declaring a domestic partnership.

Sincerely,

Benefits Administration

2026 DP Active

Risk Management Department, Benefits Administration

Phone: (213) 241-4262; Web: lausd.org/benefits

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LAUSD Domestic Partner Health Benefits Information Sheet – Active Employees

1. What benefit coverage is available to domestic partners?

An eligible domestic partner may be enrolled as a dependent in the employee's medical, dental, and/or vision plans. Medical plan coverage includes mental health services and prescription drug benefits. In addition, the domestic partner may be enrolled as a dependent in the employee-paid Optional Supplemental Life Insurance Program.

2. How do I enroll a domestic partner as a dependent?

You must submit a "Request for Change of Dependent Status" form, *notarized* "LAUSD Declaration of Domestic Partnership", and documentation establishing the relationship has existed for greater than 12 months from two of the four categories below:

- a. proof of common ownership/leasehold interest in real property;
- b. proof of common ownership of a motor vehicle;
- c. joint bank/credit account;
- d. designation as a beneficiary for life insurance or retirement benefits

If you and your domestic partner are registered with the State, in lieu of the documentation from two of the four categories, submit a copy of the certificate issued by the State.

Submit all required documents by email benefits@lausd.net, fax 213-241-4247, or mail to PO Box 513307, Los Angeles, CA 90051-1307.

3. Can the dependent child(ren) of a domestic partner be covered?

The dependent child(ren) may be covered only if the employee has adopted the children or is their legal guardian. Please visit lausd.org/benefits for additional information about the eligibility requirements for dependent child(ren) and the necessary documentation.

4. When is the domestic partner's coverage effective?

If all of the documentation is received and approved by Benefits Administration by the end of the month, coverage will be effective the first of the following month.

5. What happens if the domestic partnership is dissolved? If the employee dies?

If the domestic partnership is dissolved, coverage for the domestic partner will terminate the last day of the month in which the partnership ends. The employee must notify Benefits Administration in writing within 30 days if there is a change in status and submit a "Request for Change of Dependent Status" form, which is available on the Benefits Administration website at lausd.org/benefits/forms. If the employee dies, the domestic partner must notify the Benefits Administration immediately. *Please note that your domestic partner may be able to continue through the Federal health benefits continuation program (COBRA).*

6. If I divorce or terminate my domestic partnership, when can I add another domestic partner?

If you divorce or terminate your domestic partnership you must wait at least twelve (12) months from when Benefits Administration is notified of the divorce or termination before you can add the same or another domestic partner.

7. Is the information submitted confidential?

The information and documentation provided is used solely for determining eligibility for health benefits as a domestic partner and will remain strictly confidential. In order to provide coverage, however, pertinent dependent information (e.g. name and Social Security number) will be provided to the various health plan providers and/or the LAUSD Accounting & Disbursements Division.

8. Is the value of the domestic partner coverage reported to the Internal Revenue Service?

Yes. The Internal Revenue Service (IRS) treats the total value of the health coverage provided to the domestic partner as employee income and requires that it be reported. According to the IRS, the employee is taxed on the fair value of the coverage provided. The total value of the coverage will be included on the employee's W2 form.

9. How is the value of the domestic partner health benefit coverage determined?

In order to determine the value of the medical, dental, and vision coverage, the District uses the financial information provided by the health plans and determines the difference in cost for insuring one person versus two people. This difference is considered the fair value of the domestic partner coverage.

Note: While this approach has been used by other employers to determine the value of the coverage, the IRS has not issued regulations on how the value is determined; therefore, there is no guarantee that the IRS will agree with the amount of the taxable income reported. Please consult your tax advisor and/or attorney regarding the implications of domestic partner coverage.

10. What is the value of the coverage for 2026?

The charts below identify the monthly value of the coverage to keep your Domestic Partner enrolled for 2026 by health plan. This monthly value changes each calendar year based on the rates provided by the health plans.

MEDICAL PLANS

Anthem Blue Cross Select HMO	Anthem Blue Cross EPO	Kaiser Permanente	Health Net HMO
\$778.36	\$915.35	\$784.81	\$1,143.61

If your domestic partner is Medicare-eligible, you must provide us with a copy of his/her Medicare card that shows enrollment in Medicare Parts A and B.

DENTAL PLANS

Aetna Dental PPO	DeltaCare® USA DHMO	Western Dental (DHMO)
\$67.40	\$14.24	\$10.38

VISION PLANS

VSP	EyeMed Vision Care
\$3.58	\$3.75

Note: The District does not provide tax or legal advice on the implications of adding domestic partner coverage. Individuals should review the implications of domestic partner coverage with their own legal and/or tax counsel.

LAUSD Declaration of Domestic Partnership – Active Employees

I. Certification

Our domestic partnership began on _____

We, _____ Employee# _____
Employee (Last Name, First, M.I.)

AND

_____ SS# _____
Domestic Partner (Last Name, First, M.I.)

certify that we are domestic partners in accordance with the following criteria and eligible for benefit coverage as domestic partners under the Los Angeles Unified School District Health Benefits Program.

II. Domestic Partner Eligibility Criteria

For the purposes of LAUSD Health Benefit coverage domestic partners means two adults of the same or opposite sex who have chosen to share their lives indefinitely in an exclusive and committed relationship to the same extent as married persons, reside together, and share a mutual obligation of support for the basic necessities of life.

Based on this definition, we declare and acknowledge that we meet **all** of the following criteria:

- A. Have shared a regular and permanent residence for the past 12 months immediately preceding the application for coverage with the LAUSD.
- B. Are jointly responsible to each other for basic living expenses; basic living expenses are defined as the expenses supporting daily living (i.e., shelter, food, clothing) and contributions need not be equal.
- C. Are not currently married to another person.
- D. Have not signed a declaration of a domestic partnership with the same or another individual in the previous 12 month period.
- E. Are at least 18 years of age.
- F. Are not blood relatives any closer than would prohibit a legal marriage in the state of residence.
- G. Are mentally competent to consent to a contract.
- H. Are financially interdependent as proven by at least two of the four categories listed below, (minimum 2 documents):
 - common ownership/leasehold interest in real property
 - common ownership of a motor vehicle
 - joint bank/credit account
 - designation as a beneficiary for life insurance or retirement benefits
- I. Have documentation showing the relationship has existed for more than 12 months (This documentation may be one of the ones listed above or a third document).

HB8

III. Employee Acknowledgments

- A. I agree to notify LAUSD Benefits Administration in writing within 30 days if there is a change in our status and submit a "Request for Change of Dependent Status" form.
- B. I understand that upon notification that the domestic partnership has ended, the coverage for the domestic partner will end the last day of the month in which the relationship terminates. Further, it is understood that the domestic partner is not eligible for the Federal health benefits continuation program (COBRA) or AB528.
- C. I understand that after such termination, a subsequent Declaration of Domestic Partnership cannot be filed until twelve months after the notification in writing of the termination has been filed with LAUSD Benefits Administration.
- D. I understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statement contained in this Declaration of Domestic Partnership, including claims paid under any benefit plans in which I enroll my domestic partner.
- E. I understand that at present, the IRS considers the value of benefit coverage provided to a domestic partner as "income" to the employee. I further understand that the value of the coverage will be reported to the IRS by the District.
- F. I understand that the District is not providing legal advice and that it may be advisable to consult an attorney or tax advisor regarding the possible legal implications of filing this Declaration of Domestic Partnership.
- G. I understand that this information will be kept confidential and has been requested solely for the purpose of determining eligibility and providing LAUSD health benefits.

IV. Declaration

- A. **Employee:** I declare, under the penalty of perjury, that the foregoing is true and correct. Executed this day

_____ at _____
Date City/State

Space Below for Use by Notary Public

Print Name

Signature

Address

City/State/Zip

- B. **Domestic Partner:** I declare, under the penalty of perjury, that the foregoing is true and correct.
Executed this day

_____ at _____
Date City/State

Space Below for Use by Notary Public

Print Name

Signature

Address

City/State/Zip

HB8



Los Angeles Unified School District Benefits Administration

REQUEST FOR CHANGE OF DEPENDENT STATUS ACTIVE EMPLOYEES

Employee Number	Last Name		First Name		MI			
Address		City		State	Zip Code			
Email Address			Phone Number					
Social Security Number	☐ Male ☐ Female ☐ Non-Binary	<i>Do Not Write In Shaded Boxes</i>	Eff. Date	Process Date	Initials			
HEALTH PLANS (Select one plan from each category)								
MEDICAL								
☐ Anthem Blue Cross Select HMO ☐ Anthem Blue Cross EPO		☐ Health Net HMO ☐ Kaiser Permanente HMO		☐ Medical Opt-Out Cash Back* ☐ No Medical Coverage				
DENTAL								
☐ Aetna Dental PPO ☐ Western Dental DHMO		☐ DeltaCare® USA DHMO ☐ No Dental Coverage						
VISION								
☐ EyeMed Vision Care		☐ VSP® Vision Care		☐ No Vision Coverage				
DEPENDENT INFORMATION (Attach additional pages if necessary)								
Action	SSN	Last Name	First Name	MI	Relationship	Date of Birth	Gender	Eff. Date
☐ Add ☐ Delete					☐ Spouse ☐ Domestic Partner		☐ Male ☐ Female ☐ Non-Binary	
Reason:								
☐ Add ☐ Delete					(Son, Daughter, etc)		☐ Male ☐ Female ☐ Non-Binary	
Reason:								
☐ Add ☐ Delete					(Son, Daughter, etc)		☐ Male ☐ Female ☐ Non-Binary	
Reason:								

NOTE: Coverage for eligible employees will be effective the first day of the following month in which the form is received. Eligible dependents will be covered the first day of the following month in which the documentation to verify the dependent status is received. Refer to next page to determine documents needed. Social Security number is mandatory for all dependents. For newborns, Social Security numbers are required within two (2) months of birth.

* If you enroll in the Medical Opt-Out/Cash-Back Plan, you must attest annually that you and your eligible dependents have “minimum essential coverage” through a group health plan, and the minimum essential coverage is not from an individual market coverage such as Covered California. Attestation form is available at lausd.org/benefits/forms.

Is your spouse/Domestic Partner a LAUSD employee? ☐ Yes ☐ No Employee # _____

THIS FORM WILL NOT BE PROCESSED UNLESS SIGNED AND DATED

I understand this election will remain in effect as long as I remain eligible, or until I make another election during an annual enrollment period. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay any claim under the plan selected. I understand that I am responsible for notifying the District of any change in the eligibility of my dependents and am responsible for premiums and claims incurred on behalf of ineligible dependents. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees and providers) is subject to binding arbitration. I certify under penalty of perjury that the above information is true and is accurate to the best of my knowledge and belief.

Applicant's Signature	Date
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Instructions

In order to assist the District in ensuring that your eligible dependents are properly enrolled under your District-sponsored plan, please read and follow the instructions below.

- **Complete this form, being sure to list all dependents you wish to have added. If necessary, attach additional sheet(s) of paper to this form.**
 - a. List birthdays and Social Security numbers for all dependents. Social Security numbers are mandatory. Social Security numbers for newborns must be provided within two (2) months.
 - b. If your spouse/domestic partner is also a District employee/retiree, please list his or her employee number.
- **Provide verification of dependent status for dependents as follows:**
 - a. **Spouse** – attach a copy of your registered marriage certificate issued by the state. For new spouses, if a registered marriage certificate is received within 45 days of the marriage date, spouse will be covered effective the date of the marriage.
 - b. **Domestic Partner** – submit a notarized Declaration of Domestic Partnership form (available on lausd.org/benefits/forms) and submit the required documentation as outlined in Section II of the Declaration of Domestic Partnership form. If you and your Domestic Partner are registered with the State, in lieu of the documentation outlined in Section II, submit a copy of the certificate issued by the State. If all the required documentation is received by Benefits Administration, coverage will be effective the first of the following month.
 - c. **Natural children** – for each child, attach a copy of the official birth certificate. For newborns, if verification of birth is received within 30 days of birth, the child will be covered back to date of birth (complimentary hospital birth certificate is acceptable). If verification is submitted more than 30 days, but less than 5 months, the child will be covered on the first of the following month after the verification is received. After a child is 5 months, an official birth certificate is required.
 - d. **Stepchildren** – for each child, attach a copy of the birth certificate, a copy of your registered marriage certificate (issued by the state), and a copy of your latest income tax return showing the child's dependent status.
 - e. **Guardianship or adopted children** – for each child, attach a copy of the document verifying legal guardianship or adoption. If you submit legal documentation within 30 days of the guardianship or adoption, coverage will begin on the day of the guardianship or adoption. If submitted after 30 days, coverage will begin on the first of the following month after the legal documentation is received.
 - f. **Disabled dependent** – must meet the disability standards of the plan and must be enrolled prior to age 26.

DEPENDENTS FOR WHOM THE REQUIRED DOCUMENTATION IS NOT RECEIVED WILL NOT BE COVERED UNDER YOUR MEDICAL, DENTAL AND/OR VISION PLAN(S) UNTIL THE APPROPRIATE DOCUMENTATION IS RECEIVED.

EFFECTIVE DATE OF ADDITIONS:

Coverage will begin on the first day of the month following the receipt of the Health Benefits Enrollment form along with the required verification. **Example:** If verification and Health Benefits Enrollment form are received by Benefits Administration on January 1st, the dependent's enrollment becomes effective February 1st.

Visit lausd.org/benefits for the Optional Life Insurance Brochure for payroll deducted supplemental life insurance.

TERMINATION OF COVERAGE:

Coverage will be terminated on the last day of the month in which the employee or the dependents became ineligible.

Complete and return this form along with copies of the required documents via fax, email, or mail:

Fax: (213) 241-4247

Email: benefits@lausd.net

Los Angeles Unified School District - Benefits Administration
P.O. Box 513307
Los Angeles, CA 90051-1307

Phone: (213) 241-4262

Website: lausd.org/benefits



Los Angeles Unified School District Benefits Administration

REQUEST FOR CHANGE OF DEPENDENT STATUS UNIT F (Teacher Assistants) & UNIT G (Playground Aides)

Employee Number	Last Name		First Name		MI			
Address		City		State	Zip Code			
Email Address			Phone Number					
Social Security Number	☐ Active ☐ Retired	☐ Male ☐ Female ☐ Non-Binary	<i>Do Not Write In Shaded Boxes</i>	Eff. Date	Process Date	Initials		
HEALTH PLANS (Select one plan from each category)								
MEDICAL								
☐ Kaiser Permanente HMO		☐ Medical Opt-Out/Cash-Back*		☐ No Medical Coverage				
DENTAL								
☐ Western Dental DHMO		☐ No Dental Coverage						
VISION								
☐ VSP® Vision Care		☐ No Vision Coverage						
DEPENDENT INFORMATION (Attach additional pages if necessary)								
Action	SSN	Last Name	First Name	MI	Relationship	Date of Birth	Gender	Eff. Date
☐ Add ☐ Delete					☐ Spouse ☐ Domestic Partner		☐ Male ☐ Female ☐ Non-Binary	
Reason:								
☐ Add ☐ Delete					(Son, Daughter, etc)		☐ Male ☐ Female ☐ Non-Binary	
Reason:								
☐ Add ☐ Delete					(Son, Daughter, etc)		☐ Male ☐ Female ☐ Non-Binary	
Reason:								

NOTE: Coverage for eligible dependent(s) will be effective the first day of the following month in which the form and required documentation are received. This application will not be accepted without documentation to verify dependent status. Refer to next page to determine documents needed. Social Security number is mandatory for dependents. For newborns, Social Security numbers are required within two (2) months of birth.

* If you enroll in the Medical Opt-Out/Cash-Back Plan, you must attest annually that you and your eligible dependents have “minimum essential coverage” through a group health plan, and the minimum essential coverage is not from an individual market coverage such as Covered California. Attestation form is available at lausd.org/benefits/forms.

Is your spouse/Domestic Partner a LAUSD employee? ☐ Yes ☐ No Employee # _____

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 - e. **Guardianship or adopted children** – for each child, attach a copy of the document verifying legal guardianship or adoption. If you submit legal documentation within 30 days of the guardianship or adoption, coverage will begin on the day of the guardianship or adoption. If submitted after 30 days, coverage will begin on the first of the following month after the legal documentation is received.
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