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**CERTIFICATION OF TAX STATUS**  
**FOR**  
**DEPENDENT CHILDREN AGES 19-24**

I have enrolled my child/children ages 19 through 24 as dependents:

Name	Date of Birth	Qualifying Child Or Qualifying Relative  Yes/No

**Definitions:**

**Qualifying Child:** is one who resides with the taxpayer 50% of the year; is either under age 19, or a full-time student ages 19-23; and has not provided greater than 50% of the child's own support for the calendar year in which the taxpayer's taxable year begins. A child is no longer qualified during the year in which the child turns age 24.

**Qualifying Relative:** for health plan purposes is one who bears a special relationship to the taxpayer (blood relative or an individual who resides in the taxpayer's household); receives greater than 50% of their support from the taxpayer; and is not a qualifying child for any taxpayer for the year in question.

I understand that I am providing this information to my employer for tax reporting purposes only. I understand that my employer will rely upon this information in calculating the taxability of my share of the premium cost for coverage provided to my dependent child/children ages 19 through 24 and to determine their eligibility in the District's 125 Medical Flexible Spending Account and/or the District's Health Reimbursement Arrangement, VEBA, or HCSP.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name