SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN

CERTIFICATION OF DEPENDENT STATUS

I hereby certify that the statements below are true and correct.

1. _____ is my same-sex spouse or domestic partner on the date of this Certification.

2. I have read the notice entitled "Summary of Tax Treatment of Health Coverage Provided for Domestic Partners and Same Sex Spouses," and I understand the requirements for qualifying another person as my federal tax dependent for health coverage purposes.

3. The above person

[place your initials next to the one line that applies to you]:

_____ qualifies as my federal tax dependent for health coverage purposes in the current tax year.

OR

_____ does not qualify as my federal tax dependent for health coverage purposes in the current tax year.

4. I agree to notify the Court in writing using the attached form as soon as possible if there is any change in the above person's status as my tax dependent for health coverage purposes, including any change that may occur mid-year. I understand that any change in such status may result in the retroactive application of taxes to amounts previously paid for health coverage during the year.

5. I understand that on the basis of the above statements, the Court will decide whether to treat the above person as my tax dependent for all federal income and employment tax purposes, and that if I fail to complete this Certification or any recertification requested by the Court, then the Court will assume that the person does not qualify as my federal tax dependent for health coverage purposes.

6. I agree to reimburse the Court for any and all taxes, penalties, or other losses (including reasonable attorneys' fees) that the Court may incur as a result of its reliance on this Certification if it is untrue or incorrect in any respect, or if I fail to provide the notice required by paragraph 4 above.

_____ _____

Date Signature

_____

Type or Print Name