Stepchild Dependent Affidavit Form

In order to determine whether your stepchild qualifies for welfare benefits under this Plan, this form must be completed, notarized, and returned to the Fund Office.

PLEASE PRINT

Participant's Name: _____ Participant's SSN# or UID#: _____
(First, Middle, Last Name) (UID# can be found on your BCBS I.D. Card)

Dependent's Name: _____ Stepchild's Date of Birth: _____ / _____ / _____
(Stepchild's First, Middle, Last Name) Month Day Year

1. The Participant is the child's ☐ Step Mother ☐ Step Father

2. Is your stepchild `primarily dependent_ upon you for support? ☐ Yes ☐ No (`Primarily dependent_ means the child must live with you in a regular parent-child relationship and depend upon you for support and maintenance and the Participant will be allowed to claim the stepchild as a dependent deduction on his/her Federal income tax return.)

3. Do you assume full parental responsibility and control (including all debts) of your stepchild? ☐ Yes ☐ No

4. Does your stepchild reside with you? ☐ Yes ☐ No If not, with whom does the child reside? _____
(Mother, Father, Guardian, etc.)

_____
(First, Middle, Last Name) (Address, City, State & Zip) (Area Code & Phone Number)

5. Through the OTHER natural parent, is your stepchild insured by any other group health plan? ☐ Yes ☐ No
If yes, provide the name and address of the insurance company, **along with a copy of the front and back of the Insurance Card**:

_____
(Name of Other Natural Parent) (Date of Birth) (Name of Insurance Company)

_____
(Address, City, State & Zip of Insurance Company) (Area Code & Phone Number)

I, the Fund Participant, certify that the above named dependent is unmarried and lives with me in a regular parent-child relationship, is dependent upon me for support and maintenance and that I will be able to claim the child as a dependent deduction on my federal income taxes. I hereby certify that the information I have provided is accurate. If any of the above information is untrue, I agree to reimburse the Chicago Regional Council of Carpenters Welfare Fund for any money it was induced to pay as a result of the information I provided. I understand I have the responsibility to inform the Fund Office of any changes in the above information.

Participant's Signature: _____ Date: _____ / _____ / _____

TO BE COMPLETED BY NOTARY PUBLIC:

State of _____ County of _____

Sworn to and subscribed before me on this ____ day of _____, 20___.

(S E A L)

Notary Signature: _____