Dependent Child Other Than Own

Member SSN

Dependent Child's Details

Last Name **Gender** ◯ Male ◯ Female

First Name **Middle Initial**

Date of Birth **SSN**

Relationship

How long have you supported them? Years Months

How long have they lived with you? Years Months

Do you support this Dependent Child Completely, or do the Dependent's Biological Parents assist you in the Dependent Child's support in some degree? (If YES, please provide full details, If you require additional space, please securely attach an additional page.) ◯ Yes ◯ No

Dependent Child's Biological Mother

Name

Where are they?

Dependent Child's Biological Father

Name

Where are they?

How long ago did Dependent Child last reside with Biological Parents? Years Months

Have you taken steps to legally adopt this Dependent Child? ◯ Yes ◯ No

If YES, please provide details (If you require additional space, please securely attach an additional page.)

If NO, is it your intent that the Dependent Child shall remain in your home? ◯ Yes ◯ No

If YES, for how long? Years Months ◯ Permanently

Does this Dependent Child qualify as your Dependent on your Federal Income Tax returns? ◯ Yes ◯ No

(If YES, Please attach a copy of your most recent federal income tax return)

Please attach copies of any and all court orders or adoption papers regarding this Dependent Child

Member Acknowledgement

I hereby certify that I have completed this form correctly and that the above statements are true and complete. I understand that false or deceptive statements made on this form or in filing a claim for benefits under the Plan will result in termination of coverage and possible prosecution for fraudulent misrepresentation.

Employee Signature **Date**

This Section for Entity Benefit Coordinator Use Only

Entity Name

SEND THE ORIGINAL OF THIS PAGE TO THE PLAN ADMINISTRATOR IMMEDIATELY