

AFFIDAVIT

State of: _____)

County of: _____)

I, _____, Affiant, being first duly sworn on oath, depose and state that Affiant is making a claim for benefits on behalf of a dependent child.

1. That "dependent's" full name is: _____
2. That "dependent" was born on the following date: _____ SS# is: _____
3. That "dependent's" biological parents are: _____ & _____
4. If the dependent is your natural child, please provide **all** of the following documentation, if such documentation exists: If the following three items, have previously been furnished, no need to re-file.
____ The child's birth certificate naming you as the parent father/mother.
____ The results of a blood test establishing that you are the child's father/mother.
____ A certified copy of a court order establishing paternity/parentage.
5. Does dependent child reside with you on a full time basis at your place of residence? _____
 - a. If you answered 'yes', how long has the child lived with you on a full time basis at your place of residence? _____
 - b. If you answered 'no' to Question 5 above, please describe your relationship with the child, specifically noting the length and frequency of your visits with the child, and the child's regular place of residence.

6. Is the child primarily dependent upon you for support and maintenance? _____
 - a. If you answered 'yes', please provide copies of checks written by you for child support, if such exists. **Note, that should the Fund receive information, which indicates the child may not be primarily dependent upon you for support and maintenance, the Fund reserves the right to demand copies of your federal tax returns to verify dependent status.**
 - b. If you answered 'no' to Question 6 above, please provide the name and address of the person(s) who is (are) primarily responsible for the child's support and maintenance

7. Does the natural mother and/or father **who has custody**, have group health insurance coverage on this child? _____
If so, please advise the name of the policyholder, policy number, name, phone number and address where you would file a claim with the group insurance carrier

8. I have answered each question completely and have enclosed the requested proof with this Affidavit. (Attach additional pages if necessary) If there are any changes in any Court or Legal Documents, please send a copy along with this form.

I certify that the information supplied by me on this form is accurate and complete. I understand that any willful misrepresentation or omission will constitute grounds for termination of the insurance coverage.

*I understand that because circumstances change from time to time regarding dependents. In the event no circumstances have changed since last furnishing a form to the Fund Office, *I may complete only the dependent's name, date of birth and relationship.* Check the below listed statement that nothing has changed since I last completed the form and provide my signature, social security number or unique ID number, and the date.

Signature of Eligible Employee: _____ ID/SS# _____ Date: _____

ALL CIRCUMSTANCES REMAIN THE SAME PERTAINING TO THE ABOVE NAMED DEPENDENT AND INSURED.
YES _____ NO _____

(REQUIRED TO HAVE NOTARIZED)

Subscribed and sworn to before me this:
_____ Day of _____, 20 _____

Notary Public
Signature required _____

Seal