

**Grandchild Dependent Affidavit Form**

**In order to determine whether your grandchild 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)

Grandchild's Name: \_\_\_\_\_ Grandchild's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Grandchild's First, Middle, Last Name) Month Day Year

- 1. Is your grandchild 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 grandchild as a dependent deduction on his/her Federal income tax return.)
- 2. Do you assume full parental responsibility and control (including all debts) of your grandchild?  Yes  No
- 3. Your dependent child is the grandchild's  Mother  Father Your child's name: \_\_\_\_\_  
(First, Middle, Last Name)
- 4. Is your child still primarily dependent (as defined above) upon you for support?  Yes  No  
(In order for your grandchild to be covered under the Plan, your child must qualify as an Eligible Dependent. If your child no longer qualifies as an eligible dependent, he/she will terminate from the Plan along with your grandchild.)
- 5. Are the grandchild's natural parents (your child) married?  Yes  No
- 6. What is the name of your grandchild's OTHER natural parent? \_\_\_\_\_  
(First, Middle, Last Name) (Date of Birth)  
\_\_\_\_\_  
(Address, City, State & Zip) (Area Code & Phone Number)

- 7. Does the OTHER natural parent have insurance for your grandchild?  Yes  No **If Yes, provide a copy of the front and back of the insurance card.**
- 8. Does your grandchild 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)

I, the Fund Participant, hereby certify that the information I provided is true and 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 that if my child no longer qualifies as a dependent under the terms of Plan, coverage for my dependent child and my grandchild will be terminated. I understand that I have the responsibility to inform the Fund Office of any changes to 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\_\_\_\_. (SEAL)

Notary Signature: \_\_\_\_\_