Stepchild Coverage Verification Form

Mid-America Carpenters Regional Council Health Fund (Fund)
St. Louis-Kansas City Southern Region
1419 Hampton Avenue, St. Louis, MO 63139
Phone: (314) 644-4802, option 1 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

In order to determine whether your stepchild(ren) qualify(ies) for benefits under this Plan and to determine primary or secondary coverage, this form must be completed by the participant and returned to the Fund Office.

SECTION 1: PARTICIPANT INFORMATION

Participant Legal Last Name	Participant Legal First Name	Participant Legal Middle Name	Participant SSN or UID
Dependent Legal Last Name	**Dependent Legal First Name**	**Dependent Legal Middle Name**	**Dependent Date of Birth**

SECTION 2: DEPENDENT INFORMATION

The Participant is the child's
☐ Stepmother ☐ Stepfather

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

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 relies upon you for support and maintenance and that Participant is or will be allowed to claim the stepchild as a dependent deduction on his/her Federal income tax return.

Does your stepchild reside with you? ☐ Yes ☐ No	If No, with whom does the child reside? (list Relationship)	Last Name	First Name	Middle Name

Address	Phone Number

SECTION 3: OTHER INSURANCE INFORMATION

Does the non-custodial biological parent have OTHER group coverage for this stepchild? ☐ 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.**

Policyholder's Full Name	Relationship to Policyholder	Policyholder's Phone Number
Insurance Company Name	**Insurance Company Phone Number**	

Group ID	Participant ID	Effective Date	Coverage includes: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

SECTION 3: AUTHORIZATION

I, the Fund Participant, certify that the information I have provided is accurate. If any of the above information is untrue or incomplete, I agree to reimburse the Mid-America Carpenters Regional Council Health 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.

X _____ _____

Participant Signature **Date**