Stepchild Coverage Verification Enrollment Requirements

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: health@macbenefits.org

Eligibility Requirements:

1. Stepchildren must be **unmarried** children of the Participant's current spouse.
2. Stepchildren must maintain a qualifying **parent-child relationship** with the Participant.
3. The stepchild must **reside with** the Participant for more than one-half of the calendar year.
4. The stepchild must receive more than 50% of their **financial support** from the Participant.
5. Stepchildren must meet the following **documentation** requirements:
   - Completed Stepchild Verification **Form**
   - Copy of Divorce Decree/**Parenting Plan**
   - **Social Security Number**
   - Copy of **Birth Certificate** listing spouse as parent
   - Participant's most recent Federal Income **Tax Return** and **Signature Page**, listing the stepchild as a dependent **OR any two (2) of the following categories of documentation** from the table below.

Documentation Requirements:

Participants may submit any two (2) of the following categories of documentation.

Note: Redaction is permitted and encouraged to protect personal or unrelated financial information. Documents must clearly identify the Participant or spouse by name and demonstrate financial responsibility or support.

Stepchild Documents Table

Category	Acceptable Documentation Examples
Court or Family Support Documents	Divorce Decree or Parenting Agreement showing the Participant or spouse is responsible for certain support categories Child Support Order naming the participant or spouse as obligor
Proof of Housing Support	Mortgage statement or lease agreement showing the Participant as responsible party Utility bills in the Participant's name for the child's residence
Proof of Ongoing Expense Payments	Childcare expenses School tuition or school-related fees Clothing or supply purchases
Proof of Premium Payments	Health coverage premiums Dental coverage premiums Vision coverage premiums
School, Childcare, or Activity Records	School tuition invoice listing the Participant or spouse as payor Childcare billing statements Extracurricular or activity registration identifying the Participant or spouse as financially responsible
Proof of recurring Financial Support	Bank statements or transfer confirmations showing regular financial contributions to support the stepchild

Stepchild Coverage Verification Form

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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**