CHAUFFEURS, TEAMSTERS & HELPERS
LOCAL 301, HEALTH & WELFARE FUND
MICHAEL T. HAFFNER, CHAIRMAN
36990 NORTH GREENBAY ROAD
WAUKEGAN, IL 60087
(847) 623-3915

Single Parent Dependent Affidavit Form

In order to determine the coordination of benefits for your child under this Plan, this form must be completed 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)

Dependent's Name:_____ Child's Date of Birth: _____
(First, Middle, Last Name) Month Day Year

1. The Participant is the child's ☐ Biological Mother ☐ Biological Father

2. Does your child 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)

3. Child's OTHER biological parent's name and date of birth:

_____ _____
(First, Middle, Last Name) Month Day Year

4. Does your child's OTHER biological parent have insurance for this dependent? ☐ Yes ☐ No

_____
(Name of Insured (other biological parent)) (Name of Insurance Company)

_____
(Address, City, State & Zip of Insurance Company) (Area Code & Phone Number)

I, the Fund Participant, certify that I have never been married to this child's other biological parent and the above named dependent is unmarried. I hereby certify that the information I have provided is accurate. If any of the above information is untrue, I agree to reimburse the Teamsters Local 301 H&W 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.

Participant's Signature:_____ Date:_____/_____/ _____