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

Stepchild Dependent Affidavit Form

In order to determine how your stepchild qualifies for benefits under this Plan, this form must be completed and returned to the Fund Office.

Please include a copy of your spouse's divorce decree (front page, last page and pages pertaining to the insurance for this dependent)

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:_____ Stepchild's Date of Birth: _____
(Stepchild's First, Middle, Last Name)

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

2. Does your stepchild 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. Does the stepchild have any other group coverage? ☐ Yes ☐ No

If yes, provide the name and address of the insurance company.

_____
(Name of Other Biological Parent) (Date of Birth) (Name of Insurance Company)

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

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:_____/_____/ _____