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DEPENDENT CERTIFICATION FORM

Part A: Please complete Part A and sign the Declaration if the statements contained in paragraphs 1-2 are true as to each of your children and if you agree to comply with paragraphs 3 and 4.

I, \_\_\_\_\_ [print name], hereby make the following representations and agreement:

With regard to my children,

[Child 1] \_\_\_\_\_, Social Security # \_\_\_\_\_

If this child is employed, does his/her employer report hours to the Trust Fund Office? \_\_\_YES \_\_\_NO

If yes, is he/she a full-time student? \_\_\_YES \_\_\_NO ; Is he/she married? \_\_\_YES \_\_\_NO

[Child 2] \_\_\_\_\_, Social Security # \_\_\_\_\_

If this child is employed, does his/her employer report hours to the Trust Fund Office? \_\_\_YES \_\_\_NO

If yes, is he/she a full-time student? \_\_\_YES \_\_\_NO ; Is he/she married? \_\_\_YES \_\_\_NO

[Child 3] \_\_\_\_\_, Social Security # \_\_\_\_\_

If this child is employed, does his/her employer report hours to the Trust Fund Office? \_\_\_YES \_\_\_NO

If yes, is he/she a full-time student? \_\_\_YES \_\_\_NO ; Is he/she married? \_\_\_YES \_\_\_NO

- 1. As of the date this certification is made by me, my child has not yet reached age 26.
2. As of the date this certification is signed by me, my child is not covered by or eligible to participate (as defined below) in any employer-sponsored group health plan...
3. I agree that if my child ever becomes covered by an employer sponsored group health plan...
4. I understand that if any time prior to age 26 my child becomes covered by or is eligible to participate in an employer sponsored group health plan...

PARTICIPANT'S SIGNATURE (PRINT NAME) DATE SOCIAL SECURITY #

**Part B:** To qualify an eligible dependent(s) for tax-free coverage, please also complete Part B and sign the Declaration if the statements in paragraph 1 of Part B are true and if you agree to comply with paragraphs 2 and 3.

I, \_\_\_\_\_ [print name], hereby make the following representations and agreement:

With regard to my children,

[Child 1] \_\_\_\_\_, Social Security # \_\_\_\_\_

[Child 2] \_\_\_\_\_, Social Security # \_\_\_\_\_

[Child 3] \_\_\_\_\_, Social Security # \_\_\_\_\_

1. My child is a “qualifying child” as defined under the tax code of the state where I reside; **OR** my child is a “qualifying relative” as defined under the tax code of the state where I reside.
2. I agree to notify the Trust Fund Office within 30 days if there is any change in any of the statements contained in paragraph 1 of this Declaration (in other words, if there is any change to the status of my child as my dependent).
3. I will indemnify and hold the Plan harmless for any taxes, tax related penalties or interest imposed upon the Plan as a result of not collecting or paying taxes in reliance on this Declaration.

**Part B Signature**

I declare under penalty of perjury under the laws of the State of [**California**] that the foregoing is true and correct:

\_\_\_\_\_  
PARTICIPANT’S SIGNATURE                      (PRINT NAME)                      DATE                      SOCIAL SECURITY #

*Please complete and sign the form where requested and return or fax the form to the address listed on the other side.*