IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY BENEFIT TRUST

1470 Worldwide Place • Vandalia, Ohio 45377
Phone (937) 454-1744 • Fax (937) 454-5457
Address Mail:
PO Box 398 • Dayton, Ohio 45401–0398
Toll Free: (800) 331-4277

DEPENDENT ELIGIBILITY FOR CHILDREN UP TO AGE 19

NATURAL CHILD – If you are requesting coverage for your Natural Child, please complete Section A:

SECTION A.

I DO HEREBY STATE THAT I AM THE NATURAL PARENT OF: _____.
(DEPENDENT CHILD'S NAME)

☐ I WAS PREVIOUSLY MARRIED TO: _____.
(DEPENDENT CHILD'S OTHER PARENT AND HIS/HER DATE OF BIRTH)
ATTACH A COPY OF THE DIVORCE DECREE

☐ I WAS NEVER PREVIOUSLY MARRIED TO: _____.
(DEPENDENT CHILD'S OTHER PARENT AND HIS/HER DATE OF BIRTH)

TO THE BEST OF MY KNOWLEDGE MY DEPENDENT CHILD:

☐ DOES **NOT** HAVE ANY OTHER MEDICAL, DENTAL, AND/OR VISION INSURANCE OTHER THAN THAT OF THE IRON WORKERS BENEFIT TRUST.
☐ DOES HAVE ANOTHER MEDICAL, DENTAL, AND/OR VISION INSURANCE PLAN BESIDES THAT OF IRON WORKERS BENEFIT TRUST.

STEP-CHILD – If you are requesting coverage for your Step-Child, please complete Section B:

SECTION B.

I DO HEREBY STATE THAT MY SPOUSE, THE NATURAL PARENT OF: _____.
(DEPENDENT STEP-CHILD'S NAME)

☐ WAS PREVIOUSLY MARRIED TO: _____.
(DEPENDENT CHILD'S OTHER PARENT AND HIS/HER DATE OF BIRTH)
ATTACH A COPY OF THE DIVORCE DECREE

☐ WAS NEVER PREVIOUSLY MARRIED TO: _____.
(DEPENDENT CHILD'S OTHER PARENT AND HIS/HER DATE OF BIRTH)

TO THE BEST OF MY KNOWLEDGE MY DEPENDENT STEP-CHILD:

☐ DOES **NOT** HAVE ANY OTHER MEDICAL, DENTAL, AND/OR VISION INSURANCE OTHER THAN THAT OF THE IRON WORKERS BENEFIT TRUST.
☐ DOES HAVE ANOTHER MEDICAL, DENTAL, AND/OR VISION INSURANCE PLAN BESIDES THAT OF IRON WORKERS BENEFIT TRUST.

CUSTODIAL PARENT'S INFORMATION:

SECTION C.

Custodial Parent's Name: _____.

Custodial Parent's Mailing Address: _____.

Custodial Parent's Telephone: _____.

Custodial Parent's Date of Birth: _____.

Custodial Parent's Last Four S.S. #: _____.

I AM REQUESTING THAT THIS CHILD BE PLACED AS A DEPENDENT ON MY INSURANCE POLICY.

_____ _____-_____-_____
IRON WORKER'S PRINTED NAME SOCIAL SECURITY NUMBER

_____ _____
IRON WORKER'S SIGNATURE **DATE**

_____ _____
NOTARY SIGNATURE AND AFFIX SEAL **DATE**
NOTARY PRINTED NAME: _____
NOTARY PUBLIC, STATE OF _____, COUNTY OF _____
MY COMMISSION EXPIRES _____, 20_____.

***********THIS DOCUMENT MUST BE NOTARIZED***********

THIS DEPENDENT(S) COVERAGE IS PENDING THE RETURN OF THIS DOCUMENT.