

I.B.U. of the Pacific National Health Benefit Trust

AFFIDAVIT OF DEPENDENCY FOR DISABLED CHILD OVER AGE 26

Section I: Statement of Dependency

Name of IBU of the Pacific National Health Trust Fund Participant

Name of Disabled Child

Date of Birth

I certify that _____ is my child (biological child, legally adopted child, legal guardianship, or surviving child) and he/she meets all of the following criteria:

- Is unmarried;
- Was enrolled in an IBU of the Pacific National Health Trust Fund plan immediately before the date he/she attained age 26;
- Is unable to earn a living due to his/her mental or physical disability;
- Is dependent upon me for the majority of his/her support.

Section II: Change in Dependency

I agree to notify the IBU of the Pacific National Health Trust Fund if there is any change in my child's disability status that would make him/her no longer qualified for medical or dental coverage within 31 days of any change.

Section III: Acknowledgement

I certify under penalty of perjury, that the foregoing is true and correct. I understand as a participant that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including termination of employment.

Signature of Trust Fund Participant

Date

Address

City, State and Zip

Section IV Notary Witness

Sworn to me on this date

Notary Public

Notary Public's Address

Commission Expiration

SEAL