Stepchild Coverage Verification Enrollment Requirements

Mid-America Carpenters Regional Council Health Fund (Fund)
Northern Illinois Region
12 E. Erie St, Chicago, IL 60611
Phone: (312) 787-9455, option 3 | Fax: (312) 951-1515 | Email: submit@macbenefits.org

Eligibility Requirements:

1. Stepchildren must be unmarried children of the Participant's current spouse. The stepchild must have been born to or legally adopted by the spouse prior to the marriage and is eligible for coverage through the end of the month in which they turn age 26.
2. Stepchildren must maintain a qualifying parent-child relationship with the Participant. The stepchild must reside with the Participant for more than one-half of the calendar year (except for disabled adult stepchildren) and receive more than 50% of their financial support from the Participant.
3. Stepchildren must meet primary coverage requirements under the Plan. Primary coverage is provided only if no other person is required to provide insurance and no other coverage is available through the stepchild's biological or adoptive parents.
4. Stepchildren must meet documentation and eligibility requirements. Proof of eligibility must be provided, and coverage will terminate at the end of the month of divorce, legal separation, or death of the Participant.

Documentation Requirements:

Participants may submit any two (2) of the following categories of documentation.

Note: Redaction is permitted and encouraged to protect personal or unrelated financial information. Documents must clearly identify the Participant or spouse by name and demonstrate financial responsibility or support.

Category	Acceptable Documentation Examples
Proof of Housing Support	Mortgage statement or lease agreement showing the Participant as responsible party Utility bills in the Participant's name for the child's residence
Proof of Ongoing Expense Payments	Childcare expenses School tuition or school-related fees Clothing or supply purchases
Proof of Premium Payments	Health coverage premiums Dental coverage premiums Vision coverage premiums
School, Childcare, or Activity Records	School tuition invoice listing the Participant or spouse as payor Childcare billing statements Extracurricular or activity registration identifying the Participant or spouse as financially responsible
Proof of Recurring Financial Support	Bank statements or transfer confirmations showing regular financial contributions to support the stepchild
Court or Family Support Documents	Divorce or parenting agreement showing the Participant or spouse is responsible for certain support categories Child support order naming the Participant or spouse as the obligor

Stepchild Coverage Verification Form

Mid-America Carpenters Regional Council Health Fund (Fund)
Northern Illinois Region
12 E. Erie St, Chicago, IL 60611
Phone: (312) 787-9455, option 3 | Fax: (312) 951-1515 | Email: submit@macbenefits.org

In order to determine whether your stepchild(ren) qualify(ies) for benefits under this Plan and to determine primary or secondary coverage, this form must be completed by the participant and returned to the Fund Office.

SECTION 1: PARTICIPANT INFORMATION

Participant Legal Last Name	Participant Legal First Name	Participant Legal Middle Name	Participant SSN or UID
Dependent Legal Last Name	**Dependent Legal First Name**	**Dependent Legal Middle Name**	**Dependent Date of Birth**

SECTION 2: DEPENDENT INFORMATION

The Participant is the child's
☐ Stepmother ☐ Stepfather

Do you assume full parental responsibility and control (including all debts) of your stepchild?
☐ Yes ☐ No

Is your stepchild "primarily dependent" upon you for support?
☐ Yes ☐ No

"Primarily dependent" means the child must live with you in a regular parent-child relationship and relies upon you for support and maintenance and that Participant is or will be allowed to claim the stepchild as a dependent deduction on his/her Federal income tax return.

Does your stepchild reside with you?	If No, with whom does the child reside? (list Relationship)	Last Name	First Name	Middle Name
☐ Yes ☐ No				

Address	Phone Number

SECTION 3: OTHER INSURANCE INFORMATION

Does the non-custodial biological parent have OTHER group coverage for this stepchild? ☐ Yes ☐ No

If yes, provide the name and address of the insurance company, **along with a copy of the front and back of the Insurance Card.**

Policy Holder's Name	Policy Holder's Phone Number
Insurance Company Name	**Insurance Company Phone Number**

Group ID	Participant ID	Effective Date	Coverage includes:
			☐ Medical ☐ Dental ☐ Vision ☐ Prescription

SECTION 4: DOCUMENTATION REQUIREMENTS

*See **Stepchild Coverage Verification Enrollment Requirements** (cover page) for required documents.*

SECTION 5: AUTHORIZATION

I, the Fund Participant, certify that the above-named dependent is unmarried and lives with me in a regular parent-child relationship, is dependent upon me for support and maintenance and that I will be able to claim the child as a dependent deduction on my federal income taxes. I hereby certify that the information I have provided is accurate. If any of the above information is untrue or incomplete, I agree to reimburse the Mid-America Carpenters Regional Council Health 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.

X _____ _____

Participant Signature **Date**