



## ELIGIBLE DEPENDENT CERTIFICATION

Employee's Full Name (Please Print) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employee's Address - Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**This certification relates to the following dependent:**

Dependent's Full Name \_\_\_\_\_ Dependent's SSN \_\_\_\_\_

Dependent's Relationship to Employee \_\_\_\_\_ Dependent's Date of Birth \_\_\_\_\_

Dependent's Address - Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**I hereby certify and affirm that the dependent shown above is my (select one):**

- Biological child
- Adopted child, or child that has been placed with me for adoption (please attach a copy of placement or adoption papers)
- Step-child (please attach a copy of the child's birth certificate and proof of your relationship with the child's biological or adoptive parent; e.g. marriage certificate, etc.)
- Other dependent child who is under my legal guardianship (please attach a copy of guardianship papers or other legal documents)

**I hereby certify and affirm that I understand and agree to the following:**

1. I understand that the determination of dependent eligibility under the National IAM Benefit Trust Fund will be based on information provided in this certification.
2. I understand that it is my responsibility to notify the Fund Office immediately of any change in my relationship with this dependent or in the dependent's eligibility status.
3. I understand that I will be held responsible for reimbursement of any overpayment that occurs due to my failure to provide timely notification to the Fund Office of such changes.

**I hereby declare under penalty of law that all of the foregoing information is true:**

Employee's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_