Qualified Relative Certification Form (WF)

A B C D E F G H I J K L M N

PLUMBERS LOCAL UNION No.1 WELFARE FUND

50-02 5th Street, Long Island City, New York 11101
Tel. (718) 835-2700

(A) Member Selection *Use a ballpoint pen to complete form*

THIS APPLICATION IS BEING SUBMITTED FOR: (Please Check All Applicable Boxes)

☐ New Enrollment ☐ Address Change
☐ Change Dependent ☐ Name Change

CHANGE OF DEPENDENTS
☐ Add Dependent Date of Change MM DD YYYY
☐ Delete Dependent

(B) Member Information

(1) Social Security Number (2) Last (3) First (4) Init.

(5) Street (6) City (7) State (8) Zip

(9) Date of Birth (10) Sex M F (11) Home Phone Number

(12) E-mail Address

(13) Retired (14) Active (15) Current or Last Employer (16) Last date of Employment

(C) Qualified Relative Information: See the Welfare Fund SPD for a definition of Eligible Dependent

(1) Social Security Number (2) Last (3) First (4) Init.

(5) Street (6) City (7) State (8) Zip

(9) Date of Birth (10) Sex M F (11) Home Phone Number

(D) Certification: The Qualified Relative stated above must meet the following requirements

1. **Relationship –** ***(Please circle relationship type)*** The individual is my, child, foster child, grandchild, stepchild, brother, sister, stepbrother, stepsister, parent, stepparent, grandparent, niece, nephew, uncle, aunt, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law or an individual that for more than one half of the year resides with me and is a member of my household or in the case, of your child, the child lives with his/her other parent; and

2. **Support** – The individual depends on me for over one-half of his or her financial support in the year; and

3. **Citizenship/Residency –** The individual is a citizen or national of the United States or a resident of the United States or a contiguous country; and

4. **Dependency** – The individual is not claimed as a qualified relative by any other person.

I understand that the Fund relies on me to certify that the Qualified Relative stated above meets all the requirements as stated under Section 152(b) and (d) of the Internal Revenue Code.

Members Signature: _____ **Date:**

You must **sign and date the form** in order for your designation to be accepted by the Fund Office.

State of _____ ***County of*** _____

Sworn to before me this _____ ***Day of*** _____***, 20***_____

SIGNATURE OF NOTARY PUBLIC

MY COMMISSION EXPIRES

You may amend or revoke your designation at any time by filing another form

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