

Qualified Relative Certification Form (ASB)

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

PLUMBERS LOCAL UNION No.1 ADDITIONAL SECURITY BENEFIT 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
 Change Dependent

- Address Change
 Name Change

CHANGE OF DEPENDENTS

- Add Dependent Date of Change
 Delete Dependent

MM DD YYYY

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(B) Member Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(1) Social Security Number	(2) Last	(3) First	(4) Init.				
(5) Street	(6) City	(7) State	(8) Zip				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(9) Date of Birth	(10) Sex M <input type="checkbox"/> F <input type="checkbox"/>	(11) Home Phone Number					
(12) E-mail Address			<input type="text"/>				
<input type="checkbox"/>	<input type="checkbox"/>	(12) Current or Last Employer	<input type="text"/>		(13) Last date of Employment		
(13) Retired	(14) Active						

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(1) Social Security Number	(2) Last	(3) First	(4) Init.				
(5) Street	(6) City	(7) State	(8) Zip				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(9) Date of Birth	(10) Sex M <input type="checkbox"/> F <input type="checkbox"/>	(11) Home Phone Number					

(D) Certification:

- 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.
- Gross Income –** The individual in 2019 has less than \$4,200 of gross income.
- Support –** The individual depends on me for over one-half of his or her financial support in the year.
- Citizenship/Residency –** The individual is a citizen or national of the United States or a resident of the United States or a contiguous country.
- 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