



Southern California  
 United Food & Commercial Workers Unions  
 and Food Employers Benefit Fund  
 6425 Katella Avenue • P.O. Box 6010, Cypress, CA 90630-0010  
 714-220-2297 • 562-408-2715

## Application for Coverage Of A Child As An Eligible Dependent Pending Adoption Placement

### Eligibility Requirements For Children Placed For Adoption

In order for the child to be covered, you must submit the following:

- Completed application.
- Copy of Petition to Adopt.

If adoption is not finalized within 9 months, this application must be completed annually and include a copy of your federal income tax return to verify that you claim the child as a dependent for tax purposes.

### When Coverage Begins

A child who is placed in a Participant's home for adoption will be covered effective with the date of the placement in the home and will continue for nine months, as documented by a temporary adoption decree, provided the appropriate documents are received by the Fund.

When copies of the final adoption papers are provided to the Fund Office, the child's eligibility will continue as a natural dependent.

### Participant's Information

Last Name			First Name			M.I.	Social Security Number					
Mailing Address			City			State	Zip Code			Date Of Birth		
Telephone Number			Email Address			Employer						
Employer's Address			City			State	Zip Code			Union Local		

### Spouse or Domestic Partner Information

Last Name			First Name			M.I.	Date Of Birth			Social Security Number					
Employer's Address			City			State	Zip Code			Union Local					

### Other Coverage

Are you or your spouse or domestic partner covered under another health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Under Medicare? <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Employer			Name Of Other Insurance Company/Plan					
Has your spouse or domestic partner filed for coverage for this child under his/her plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please submit a copy of the acceptance or denial. If no, state reason _____				Does your spouse or domestic partner have a job which makes him/her eligible for coverage under this Trust Fund? <input type="checkbox"/> Yes <input type="checkbox"/> No								
				Does the adoptive child have coverage under this Fund or under any other plan of benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No								

### Adoptive Child's Information

Last Name			First Name			Middle Initial					
Social Security Number			Date of Birth			<input type="checkbox"/> Male <input type="checkbox"/> Female					

Date of placement in home establishing the child's status as your pending or adoptive child: \_\_\_\_\_ Day \_\_\_\_\_ Month \_\_\_\_\_ Year

Explain the status of the adoption and/or attach any documents. \_\_\_\_\_

Do you claim the child as a dependent for federal income tax purposes?  Yes  No

If yes, please attach copy of your most recent Form 1040 to this application. If the answer is no, please write an explanation below: \_\_\_\_\_

### Participant's Certification

I hereby certify that the above statements and answers are true and complete to the best of my knowledge.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse/Domestic Partner Signature \_\_\_\_\_ Date \_\_\_\_\_