United Food and Commercial Workers
Unions and Employers Midwest Health Benefits Fund
Administered by Wilson-McShane Corporation

1431 Opus Place, Suite 350
Downers Grove, IL 60515

I, _____, the undersigned affiant, residing at

_____
(street address) (city) (state) (zip code)

Behind duly sworn on oath, do depose and say that:

1. _____, born on _____
(name of dependent) (month) (day) (year)

for whom application is made for coverage under the Group Insurance Plan for the employees of:

_____
(name of union)

☐ is ☐ is not related to the affiant, and such relationship is: _____

2. The Natural Parents of said child are:

a. ☐ Divorced (send copy of complete Divorce Decree)
☐ Separated
☐ Never Married (send copy of Qualified Medical Child Support Order)

b. Father's name: _____ ☐ Living ☐ Deceased
Father's Date of Birth: _____
Father's present address:
_____
(street address) (city) (state) (zip code)
Father's present employer (if known): _____
Name of father's insurance company: _____
☐ Single coverage ☐ Family coverage ☐ Medical Only ☐ Medical and Dental

c. Mother's name: _____ ☐ Living ☐ Deceased
Mother's Date of Birth: _____
Mother's present address:
_____
(street address) (city) (state) (zip code)
Mother's present employer (if known): _____
Name of mother's insurance company: _____
☐ Single coverage ☐ Family coverage ☐ Medical Only ☐ Medical and Dental

3. Said child receives support from: _____
In the amount of $_____ per ☐ Week ☐ Month ☐ Year

4. Affiant will claim the child as a federal income tax deduction for the year _____, and has so claimed said child for the years of: _____.

5. Child's address: _____
(street address) (city) (state) (zip code)

Subscribed and sworn to before me this:

_____day of _____, _____

Notary Public:_____ _____
(signature of affiant)

Y122