# AFFIDAVIT OF DEPENDENCY

## PARENT(S)

YOU ARE REQUIRED TO COMPLETE **ALL** QUESTIONS IN THIS FORM (FRONT AND BACK). SUBMIT TO THE PLAN OFFICE **ALL** DOCUMENTATION REQUESTED. A SEPARATE AFFIDAVIT SHOULD BE COMPLETED FOR EACH DEPENDENT. A DETERMINATION WILL BE MADE AS TO YOUR DEPENDENT'S ELIGIBILITY TO COVERAGE UPON RECEIPT OF **ALL** DOCUMENTATION.

A NEW AFFIDAVIT IS REQUIRED EACH YEAR.

**PART I**

EMPLOYEE'S NAME_____ SS#_____

/☐/ Active Employee*
/☐/ Pilot - Branch No. _____
/☐/ Other _____

***PENSIONERS MAY NOT CLAIM DEPENDENT PARENT(S)**

DEPENDENT'S FULL NAME_____SS#_____

**RELATIONSHIP**

/☐/ MOTHER DATE OF BIRTH _____

/☐/ FATHER DATE OF BIRTH _____

> a) Was the above your Dependent at the time the expense was incurred YES ☐ NO ☐

> b) Does this Dependent currently reside in your home YES ☐ NO ☐

> c) Have you claimed this Dependent on your Federal Income Tax Return for the preceding calendar year YES ☐ NO ☐
If **YES**, list all years claimed_____

> d) Is this Dependent covered under another Group Health Plan YES ☐ NO ☐
If **YES:**
Name of Carrier_____
Policy Number_____
Effective Date of Coverage_____

> e) Is this Dependent covered under Medicare YES ☐ NO ☐
If **YES**, Effective Date_____
Part A /☐/ Part B /☐/

> f) Is this Dependent currently listed on your M.M.& P. Beneficiary Card YES ☐ NO ☐



**Form No. 92B**
**Rev. 10/96**

(OVER)

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**PART II - SUPPORTING DOCUMENTS**

The Plan will only consider eligibility for this Dependent if proof acceptable to the Trustees is submitted by the Employee through the Plan Office.

The following applicable documents must be submitted:

1) Income Tax Return From 1040 for the preceding year

2) Copy of Medicare Enrollment Card*

3) If covered by another Group Health Plan, enclose copy of ID card or other proof.

*If Dependent is eligible to Medicare

* * * * * * * * * *

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

I understand that if insufficient or incomplete documentatic is submitted, the Plan Office will be unable to make a determinatio concerning my dependent's eligibility to benefits under the M.M.& P. Health and Benefit Plan.

_____ _____

(Date) (Signature)



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## M.M.& P. HEALTH & BENEFIT PLAN RULES

Following is an excerpt of the Plan provision covering your Dependent:

"c. Parent(s).

An Eligible Employee may designate his parent or parents as his Dependents by filing a beneficiary designation form with the Plan Office, provided however, that at the time of occurrence of a claim involving such parent:

1. The Eligible Employee does not have a Spouse or Child who falls within the definition of the term "Dependent" as defined in these Rules and Regulations.

2. The parent or parents designated by the Eligible Employee as his Dependent or Dependents have been claimed as dependent(s) for tax exemption purposes in the Employee's Federal Income Tax Return for the calendar year preceding the date on which a claim is incurred."