

B. Name _____
Relationship to you _____
Date of Birth _____ If child lives with you, check here
Social Security Number _____

C. Name _____
Relationship to you _____
Date of Birth _____ If child lives with you, check here
Social Security Number _____

If you have more than three (3) dependents, please request an additional Registration Form from the Fund Office.

8. For each child listed above who is not living with you, please provide the following information:

Child's Name _____ Name of Person with Whom Child is residing _____

Address _____

Child's Name _____ Name of Person with Whom Child is residing _____

Address _____

Child's Name _____ Name of Person with Whom Child is residing _____

Address _____

II. Health

1. Is the child physically or mentally disabled?

Child's Name _____

Yes No

Child's Name _____

Yes No

Child's Name _____

Yes No

If yes, you must furnish proof of the child's incapacity within 31 days after the date on which the child would lose coverage. The Trustees may periodically request proof of the continued incapacity of the child.

2. Date incapacity arose _____

IF THE CHILD IS UNDER 19 YEARS OF AGE, SKIP SECTION III. IF THE CHILD IS INCAPACITATED, SKIP SECTION III.

III. Enrollment In School

1. If the child is 19 years of age or older and unmarried, please state whether the child is presently enrolled full-time in an accredited college, university, or other institute of higher learning.

Child's Name Yes No

Child's Name Yes No

Child's Name Yes No

2. If the answer to No. III (1) is yes, please provide the name and address of the institution.

Child's Name _____
Name of Institution

Address of Institution

Child's Name _____
Name of Institution

Address of Institution

Child's Name _____
Name of Institution

Address of Institution

YOU NEED NOT COMPLETE SECTION IV IF THE CHILD RESIDES IN YOUR HOUSEHOLD.

IV. Proof Of Support--It may be necessary, at the discretion of the trustees, that you furnish a copy of your Federal or State Income Tax Return for the previous year showing that you claimed this child as a dependent.

I have determined by review of all applicable records that I have contributed at least ____% of my child's support during the previous year.

I hereby certify the above information is true and accurate to the best of my knowledge.

SIGNATURE OF PARTICIPANT

Return this completed form to the Fund Office.

**Plumbers and Steamfitters Local 106
Health and Welfare Fund
822 North Lakeshore Drive
Lake Charles, Louisiana 70601**