Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle WA 98111

Stepchild Update

Participant's name: ______________________________

Participant's member number: ______________________________

Child's name: ______________________________

To help us keep our eligibility files current, please provide us with the following information.

1. Does this child live with you? ____ Yes ____ No. If no, with whom and where does this child live?

   ____

   During what period of time did this child live with you? ______________________________

   When did the child's residency change? ______________________________

   Why did the child's residency change? ______________________________

2. If the child lives elsewhere, what is that person's relationship to the child? ______________________________

3. Is this child covered under any other health care plan? ____ Yes ____ No. If yes, please provide the name and telephone number of the health care plan and the name, social security number and identification number of the insured. Please include a copy of the insurance card(s):

   Medical coverage including effective date of coverage:

   ____

   Prescription coverage including effective date of coverage:

   ____

   Dental coverage including effective date of coverage:

   ____

   Vision coverage including effective date of coverage:

   ____

I hereby certify that the foregoing statements are true, correct and complete to the best of my knowledge.

______________________________ ______________________________

Participant's Signature Date