



North Atlantic States Carpenters
Health Benefits Fund

Buffalo Office
1159 Maryvale Dr., Suite 20
Cheektowaga, NY 14225
Phone: (716) 839-7132
Toll Free: 1(877) 739-7136
Fax: (716) 839-7136
www.carpentersfund.org.

South Central Office
181 Industrial Park Road
Horseheads, NY 14845
Phone: (607) 739-1326
Toll Free: 1(866) 727-0281
Fax: (607) 739-1415
ncf.carpenters.fund

FINANCIAL DEPENDENT DECLARATION OF TAX STATUS 2023
(Needed to determine eligibility for dental benefits)

The North Atlantic States Carpenters Health Benefits Fund (the “Plan”) provides dental benefits to eligible participants and their biological, adopted and step children between ages 19 and 26 (“Adult Children”) who qualify as a tax dependent under the Internal Revenue Code for purposes of receiving income tax exempt health benefits. The purpose of this declaration is to ascertain and document tax dependent status of the participant’s Adult Children. As the following determination is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances.

Qualifications:

Adult Children are considered tax dependents for purposes of employer-provided health benefits only if **ALL** of the following requirements are met:

1. Adult Child and participant live together (share principal residence)*
2. Adult Child receives more than half of his or her support from the participant
3. Adult Child is a U.S. Citizen, U.S. resident alien, U.S. National, or a resident of Canada or Mexico.

*Unless the Adult Child:

1. Receives over one-half of support during the calendar year from the child’s parents who are:
 - i. divorced or legally separated under a decree of divorce or separate maintenance;
 - ii. separated under a written separation agreement; or
 - iii. live apart at all times during the last 6 months of the calendar; And
2. Is in the custody of one or both of his/her parents for more than one-half of the calendar year.

Certification:

I understand:

- That the Plan has a legitimate need to know residential and financial information about me and my Adult Child.
- That an Adult Child is eligible for dental coverage under the Plan only if all of the aforementioned requirements are met.
- That this declaration may have legal implications under federal and/or state law.
- A civil action may be brought against me for any losses, including reasonable attorneys’ fees, if I have made a false statement in this declaration.
- I must notify the Plan if there is a change in my status within 30 days of the change.

I declare:

- My Adult Child meets all the aforementioned requirements for the 2023 calendar year.
- That the information I have provided is true, complete, and correct. If it is not, or if I do not update this information within 30 days of a change in status, I may be liable for any claims or premiums paid by the Fund on my behalf and my Adult Child’s behalf.

(OVER)



North Atlantic States Carpenters
Health Benefits Fund

Buffalo Office
1159 Maryvale Dr., Suite 20
Cheektowaga, NY 14225
Phone: (716) 839-7132
Toll Free: 1(877) 739-7136
Fax: (716) 839-7136
www.carpentersfund.org.

South Central Office
181 Industrial Park Road
Horseheads, NY 14845
Phone: (607) 739-1326
Toll Free: 1(866) 727- 0281
Fax: (607) 739-1415
ncf.carpenters.fund

Name of Participant: _____

Name of Adult Child: _____

Participant's signature: _____ Date: _____

Please see below this document is required to be notarized.

STATE OF: _____

COUNTY OF: _____

Before me, the undersigned authority, a Notary Public in and for said County and State, on this day personally appeared _____ known to me to be the persons whose names are subscribed to the foregoing instrument, and acknowledges that they have signed this affidavit as a free and voluntary act of the used and purposes therein set forth.

GIVEN UNDER MY HAND AND SEAL THIS _____ DAY OF _____ 20_____.

NOTARY PUBLIC

IN AND FOR _____ COUNTY, STATE OF _____.

MY COMMISSION EXPIRES:
