

BAKERY AND CONFECTIONERY UNION AND INDUSTRY INTERNATIONAL HEALTH BENEFITS AND PENSION FUNDS

ENROLLMENT FORM (Please Print)

Participant Information

Social Security Number:

-

 -

Last Name:

Suffix: (Jr, Sr, II, III)

First Name:

Middle Name:

Home Telephone Number:

Date of Birth:

-

 -

-
 -

Gender: Fill In One:

Marital Status: Fill In One:

Male Female

Single Married Separated Divorced Widowed

Home Address:

City:

State:

Zip Code:

Spouse Information

Spouse's Social Security Number:

Date of Birth:

-

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-
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Last Name:

Suffix: (Jr, Sr, II, III)

First Name:

Middle Name:

(Dependent Children Information on Other Side)

Mail completed form to:

**Bakery And Confectionery Union And Industry
International Health Benefits And Pension Funds
10401 Connecticut Avenue
Kensington, MD 20895**

Dependent Children Information

You must certify compliance with IRS financial support rules for each of your children listed below. Your signature below is a certification that each child meets the applicable support rule — either **A, B, C, or D** — for the current calendar year.

A. Children from birth to the end of the year in which their 18th birthday occurs: You certify that the child does not provide more than one-half of his or her own support, and that you will notify the Fund immediately if the child begins to provide more than half of his or her own financial support.

B. Children who are not full-time students, from January 1 of the year in which the 19th birthday occurs until the 19th birthday: You certify that you provide more than half of the child's financial support, and that you will notify the Fund immediately if you no longer provide more than half of the child's financial support.

C. Children who are full-time students, from January 1 of the year in which the 19th birthday occurs until the end of the year in which the 22nd birthday occurs: You certify that the child does not provide more than one-half of his or her own support, and that you will notify the Fund immediately if the child begins to provide more than half of his or her own financial support.

D. Children who are full-time students, from January 1 of the year in which the 23rd birthday occurs until the 25th birthday: You certify that you provide more than half of the child's financial support (you may disregard scholarships from an accredited educational institution), and that you will notify the Fund immediately if you no longer provide more than half of the child's financial support.

Relation to You: Fill In One: Son Daughter Stepson Stepdaughter Other

If Other, Enter Description

Dependent's Social Security Number: - -

Date of Birth: - -

Last Name: **Suffix: (Jr, Sr, II, III)**

First Name: **Middle Name:**

Relation to You: Fill In One: Son Daughter Stepson Stepdaughter Other

If Other, Enter Description

Dependent's Social Security Number: - -

Date of Birth: - -

Last Name: **Suffix: (Jr, Sr, II, III)**

First Name: **Middle Name:**

Relation to You: Fill In One: Son Daughter Stepson Stepdaughter Other

If Other, Enter Description

Dependent's Social Security Number: - -

Date of Birth: - -

Last Name: **Suffix: (Jr, Sr, II, III)**

First Name: **Middle Name:**

Date Signed:

- -

Your Signature — Full Name