

**UNITED FOOD AND COMMERCIAL WORKERS & EMPLOYERS**  
**Arizona Health & Welfare Trust**

ADMINISTRATOR: Southwest Service Administrators, Inc. • www.southwestservicetpa.com  
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**ADULT DEPENDENT CERTIFICATION FORM**

I, \_\_\_\_\_ [print name], hereby make the following representations and agreements:

1. As of the date this certification is made by me, I am at least 18 years of age but have not yet reached age 26. (date of birth: : \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_)
2. I certify as follows:
  - A. My Social Security Number is: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
  - B. I am employed: \_\_\_\_\_YES \_\_\_\_\_NO
  - C. My spouse is employed: \_\_\_\_\_YES \_\_\_\_\_NO \_\_\_\_\_NOT MARRIED
  - D. I am eligible to enroll, or have enrolled, in a Group Health Plan (as defined in Item 3 below ) offered by my employer or my spouse's employer: \_\_\_\_\_YES \_\_\_\_\_NO
3. As of the date this certification is signed by me, I am not covered by or eligible to participate (as defined below) in any employer-sponsored group health plan, either through my own employment or (if I am married) my spouse's employment. Eligibility under a Group Health Plan available through either of my parents is not considered under this certification.  
  
"Group health plan" means any plan, policy, or program that provides benefits or coverage for hospital or medical services. "Eligible to participate" means that I could participate but have chosen not to be covered.
4. I agree that if I ever become covered by a group health plan (other than as a dependent of a plan of one of my parents), or if I become eligible to participate in such a group health plan but choose not to participate in that plan, I will promptly notify this Trust Fund.
5. I understand that if any time prior to age 26 I become covered by or am eligible to participate in a group health plan (other than as a dependent of a plan of one of my parents), then I will not be eligible for coverage under, and cannot receive any benefits from, this Trust Fund as a dependent child. If I receive benefits from this Trust Fund while covered or eligible to participate in another group health plan, I agree to promptly repay all such benefits to this Trust Fund.

I declare under penalty of perjury under the laws of the State of Arizona and the United States that the foregoing is true and correct.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_

**AGREEMENT BY PARENT PARTICIPANT:**

I, \_\_\_\_\_ [print name] am the parent of the dependent who is making the above certification, and by reason of my employment I am a participant in the Trust Fund.

My Social Security Number is: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I agree to be jointly and severally liable for the repayment of any benefits that are described in the above certification.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_