

**Transportation • Communications • International Union**

Los Angeles Metropolitan Transportation Authority  
Health & Welfare Trust Fund

Administered By: Benefit Programs Administration  
Telephone • (562) 463-5090 • (800) 427-5342

**DEPENDENT CERTIFICATION FORM**

*Adult child must complete this form if applying for enrollment in the Trust Fund*

I, \_\_\_\_\_ [print name], hereby represent and agree that:

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.
2. As of the date this certification is signed by me, I am not eligible to participate in any employer-sponsored group health plan (as defined below), either through my own employment or (if I am married) through my spouse's employment.

"Employer-sponsored group health plan" means any group plan, policy, or program that provides benefits or coverage for hospital or medical services by an employer to an employee. "Eligible to participate" means that I could participate without regard to whether I have chosen not to be covered.

3. If I ever become eligible to participate in an employer-sponsored group health plan (other than as a dependent of a plan of one of my parents), I will promptly notify the Trust Fund, regardless of whether or not I choose to participate in that plan. Notice will be made to the Trust Fund at:

Transportation Communications International Union  
Los Angeles Metropolitan Transportation Authority  
Health & Welfare Trust Fund  
13191 Crossroads Parkway North Suite 205  
City of Industry, CA 91766

4. I understand that if any time prior to age 26 I am eligible to participate in an employer-sponsored group health plan (other than as a dependent of a plan of one of parents), then I cannot receive any benefits from the Trust Fund. If I receive benefits from the Trust Fund while eligible under such other group health plan, I agree to promptly repay all such benefits to the Trust Fund. Further, if any lawsuit is brought against me to recover any portion of the fore described benefits then I agree to pay the Trust Fund's reasonable attorneys' fees and costs in such lawsuit.

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

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

**AGREEMENT BY PARENT PARTICIPANT:**

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

I agree to be jointly and severally liable for the repayment of any benefits, including attorneys' fees and costs, which are described in Paragraph 4 of the above certification.

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

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