ILWU-PMA WELFARE PLAN • 1188 FRANKLIN ST., SUITE 300 • SAN FRANCISCO, CA 94109 • (415) 673-8500

DEPENDENT CHILD CERTIFICATION FORM

This form must be completed for each dependent child who is NOT your (1) natural child, (2) legally adopted child, (3) step child (that is, your spouse's child), (4) foster child, (5) children under a legal guardianship, or (6) same sex domestic partner's child. List each child on a separate form. ***This form must be notarized and returned to the Benefit Plans Office.***

Employee's name____Local/Reg No.____________________

1. Child's Name ________________________________Child's Birthdate ________/______/__________

   Child's relationship to you ____

2. Does this child live with you?...☐ YES ☐ NO

   If **NO**, where and with whom does the child live? _____________________________________

   ____

3. Does this child rely on you for the majority (more than half) of his/her support - food, clothing, housing, and medical care? .... ☐ YES ☐ NO

4. Is the child's natural parent supporting this child? .... ☐ YES ☐ NO

   If **YES**, explain:____

   ____

   ____

5. Do you have a parent/child relationship with this child?....................................☐ YES ☐ NO

6. Do you have authority to act as the parent of this child?..................................☐ YES ☐ NO

   If **NO**, explain:____

   ____

   ____

CERTIFICATION: I certify that all information on this form is true and correct, and agree to provide any additional information the Trustees may request. ***I understand that if I misstate or misrepresent any information on this form, my dependents and I may each lose eligibility for benefits under the ILWU-PMA Welfare Plan.***

_________________________ ____

Date **Employee Signature**

State of ____________________ **NOTARIZATION REQUIRED**

County of ____________________

On__________________, before me, ____________________________________, Notary Public,

personally appeared____________________________________, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument. I certify under PENALTY OF PERJURY under the laws of the State in which this was signed that the foregoing paragraph is true and correct.

Witness my hand and official seal.

[seal]

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Signature of Notary Public My commission expires______________________

ILWU-PMA WELFARE PLAN • 1188 FRANKLIN ST., SUITE 101 • SAN FRANCISCO, CA 94109
(415) 673-8500 • FAX (415) 749-1400

IMPORTANT NOTICE REGARDING TAXATION

If you have a dependent child or same-sex domestic partner (or same-sex spouse) who is eligible for coverage under the terms of the ILWU-PMA Welfare Plan but who does not qualify as a dependent under Section 152 of the Internal Revenue Code (i.e., is a "non-exempt" dependent)[1], the fair market value of the dependent coverage under the Plan will be reported as taxable income for federal tax purposes. If you are an active employee, you can (i) elect to either pay to the Benefit Plans Office (BPO), in installments, federal income and payroll taxes on the fair market value of the dependent coverage or (ii) have such taxes withheld from your regular paycheck. If you are not an active employee you will be required to pay such taxes, in installments, to the BPO. In addition, if you work in a state that treats your same-sex domestic partner (or same-sex spouse) and his or her children as non-exempt dependents, the fair market value of the dependent coverage for your same-sex domestic partner (or same-sex spouse) and his or her children under the Plan will be reported as taxable income for state tax purposes. If you are an active employee, you can (i) elect to either pay to the BPO, in installments, state income and payroll taxes on the fair market value of such coverage or (ii) have such taxes withheld from your regular paycheck. If you are not an active employee you will be required to pay such taxes, in installments, to the BPO.

Effective March 30, 2010, the Patient Protection and Affordable Care Act has mandated group health coverage for certain over-age children who would have otherwise been deemed non-exempt dependents. The Internal Revenue Code and some state laws have consequently allowed such coverage to be provided without requiring participants to pay taxes on the value of that dependent coverage, even if the participant does not claim the dependent as a tax dependent on his or her tax return. The favorable tax treatment for such coverage depends on the nature of the relationship between the participant and the over-age child and would apply to a child (under the age of 27 for the entire calendar year) who is your natural child, legally adopted child, step child or eligible foster child.

Participants are not required to include in taxable income or pay income or payroll taxes on the value of dependent coverage for any otherwise eligible dependent who qualifies as a dependent under Section 152 (modified as described in footnote 1), who is the participant's opposite sex spouse, or who is an over-age child who qualifies for the favorable tax treatment described in the preceding paragraph (each, an "exempt dependent").

A child of a same-sex domestic partner (or same-sex spouse) or a child who is not your natural child, legally adopted child, step child, or eligible foster child will qualify as a dependent under Section 152 for federal tax purposes if the child:

(1) is a citizen, resident, or national of the United States;
(2) resides with you as a member of your household;
(3) receives the majority of his or her annual support (food, clothing, housing, and medical care) from you; and
(4) is not a "qualifying child" (as defined in Section 152) of another taxpayer.[2]

A same-sex domestic partner (or same-sex spouse) will qualify as a dependent under Section 152 for federal tax purposes if he or she:

(1) is a citizen, resident, or national of the United States;
(2) resides with you as a member of your household;
(3) receives the majority of his or her annual support (food, clothing, housing, and medical care) from you; and
(4) is not a "qualifying child" (as defined in Section 152) of another taxpayer.

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[1] Note, however, that if a dependent child, same-sex domestic partner or same-sex spouse does not qualify as a dependent under Section 152 only because his or her gross income exceeds the gross income limitation under Section 152(d)(1)(B) and/or he or she filed a joint federal income tax return with his or her spouse, then such person will be considered to be an "exempt" dependent for purposes of determining if the value of coverage for such person under the Plan is taxable income (i.e., the coverage will not be taxable).

[2] A child of a same-sex domestic partner in a domestic partnership registered in California, Oregon or Washington who is not your legally adopted child, step child or eligible foster child is treated, for purposes of the tax laws of the state of registration, as your natural child, and the rules for determining if such child qualifies as a Section 152 dependent are the same as the rules that would apply to your natural child. Also, special rules may apply to same-sex spouses and children of same-sex spouses. Please contact your tax advisor if you have any questions concerning the taxation of coverage for a same-sex spouse or the children of a same-sex spouse.

(over)

A same-sex domestic partner will qualify as a dependent for California, Oregon or Washington state tax purposes if you and your domestic partner are registered domestic partners in such state. A same-sex spouse will generally be treated the same as an opposite-sex spouse for state tax purposes in those states that recognize the marriage.

The rules governing who qualifies as a "dependent" for purposes of determining the tax treatment of coverage provided under the terms of the ILWU-PMA Welfare Plan can be complex. You are therefore strongly advised to consult with your own tax advisor should you have any questions about such tax treatment.

Please use the form on the bottom of this page of this Notice to indicate whether the exemption criteria listed in this Notice are met for the dependent(s) you wish to add (or were previously enrolled) to your ILWU-PMA Welfare Plan coverage.

Certification Form

Employee's Name______________________________ Local/Reg No__________

Please list the dependents you are adding to your ILWU-PMA Welfare Plan coverage and indicate by checking "YES" which dependents are "exempt dependents" as described above. If they do not meet the criteria, check "NO". If you mark "NO" in this section, the dependent coverage will be reported as taxable income for federal and state tax purposes as described above, unless the dependent is your natural child, legally adopted child, step child or eligible foster child or you provide proof that the dependent is your same-sex spouse, registered domestic partner, the child of your same-sex spouse or the child of your registered domestic partner, in which case the dependent coverage will be reported as taxable income for federal tax purposes and may be reported as taxable income for state tax purposes.

Dependent Name:	Relationship:	Date of Birth:	YES	NO
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

DOCUMENTATION REQUIRED:

You will need to submit Worksheet 1, IRS Publication 501, for each dependent you marked "YES" who is any of the following: (1) a same-sex domestic partner or same-sex spouse, (2) a same-sex domestic partner's or same-sex spouse's child, (3) a dependent child over the age of 26 that is permanently and totally disabled, (4) an individual that is not your natural child, legally adopted child, step child or eligible foster child, or (5) any child for whom you submit a notarized Dependent Child Certification Form. If any dependent listed above is your registered same-sex domestic partner, same-sex spouse, the child of your registered same-sex domestic partner or the child of your same-sex spouse, you will need to submit valid state or county documentation proving that you and your domestic partner or spouse are registered or married.

CERTIFICATION: I certify that all information on this form is true and correct, and agree to provide any additional information the Trustees may request. ***I understand that if I misstate or misrepresent any information on this form, my dependents and I may each lose eligibility for benefits under the ILWU-PMA Welfare Plan.***

Employee Signature:__________________________ Date:________________

Funds Belonging to the Person You Supported

1.	Enter the total funds belonging to the person you supported, including income received (taxable and nontaxable) and amounts borrowed during the year, plus the amount in savings and other accounts at the beginning of the year. Do not include funds provided by the state; include those amounts on line 23 instead	**1.**	
2.	Enter the amount on line 1 that was used for the person's support	**2.**	
3.	Enter the amount on line 1 that was used for other purposes	**3.**	
4.	Enter the total amount in the person's savings and other accounts at the end of the year	**4.**	
5.	Add lines 2 through 4. (This amount should equal line 1.)	**5.**	

Expenses for Entire Household (where the person you supported lived)

6.	Lodging (complete line 6a or 6b):		
	6a. Enter the total rent paid	**6a.**	
	6b. Enter the fair rental value of the home. If the person you supported owned the home, also include this amount in line 21.	**6b.**	
7.	Enter the total food expenses	**7.**	
8.	Enter the total amount of utilities (heat, light, water, etc. not included in line 6a or 6b)	**8.**	
9.	Enter the total amount of repairs (not included in line 6a or 6b)	**9.**	
10.	Enter the total of other expenses. Do not include expenses of maintaining the home, such as mortgage interest, real estate taxes, and insurance.	**10.**	
11.	Add lines 6a through 10. These are the total household expenses	**11.**	
12.	Enter total number of persons who lived in the household	**12.**	

Expenses for the Person You Supported

13.	Divide line 11 by line 12. This is the person's share of the household expenses	**13.**	
14.	Enter the person's total clothing expenses	**14.**	
15.	Enter the person's total education expenses	**15.**	
16.	Enter the person's total medical and dental expenses not paid for or reimbursed by insurance	**16.**	
17.	Enter the person's total travel and recreation expenses	**17.**	
18.	Enter the total of the person's other expenses	**18.**	
19.	Add lines 13 through 18. This is the total cost of the person's support for the year	**19.**	

Did the Person Provide More Than Half of His or Her Own Support?

20.	Multiply line 19 by 50% (.50)	**20.**	
21.	Enter the amount from line 2, plus the amount from line 6b if the person you supported owned the home. This is the amount the person provided for his or her own support	**21.**	
22.	Is line 21 more than line 20?		

☐ **No.** You meet the support test for this person to be your qualifying child. If this person also meets the other tests to be a qualifying child, stop here; do not complete lines 23–26. Otherwise, go to line 23 and fill out the rest of the worksheet to determine if this person is your qualifying relative.

☐ **Yes.** You do not meet the support test for this person to be either your qualifying child or your qualifying relative. **Stop here.**

Did You Provide More Than Half?

23.	Enter the amount others provided for the person's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts included on line 1.	**23.**	
24.	Add lines 21 and 23	**24.**	
25.	Subtract line 24 from line 19. This is the amount you provided for the person's support	**25.**	
26.	Is line 25 more than line 20?		

☐ **Yes.** You meet the support test for this person to be your qualifying relative.

☐ **No.** You do not meet the support test for this person to be your qualifying relative. You cannot claim an exemption for this person unless you can do so under a multiple support agreement, the support test for children of divorced or separated parents, or the special rule for kidnapped children. See *Multiple Support Agreement*, *Support Test for Children of Divorced or Separated Parents or Parents Who Live Apart*, or *Kidnapped child* under *Qualifying Relative*.

Employee name:________________________ Local / Reg No. __________

Dependent name:________________________ Date of birth __________