



DISABLED DEPENDENT CHILD AFFIDAVIT

In the matter of _____, dependent of
(Name of Dependent Child) (Dependent Date of Birth)

_____, who is a member of the United
(Member's Complete Name) (Social Security Number)

Federation of Teachers Welfare Fund and who resides at _____
(Member's Complete Address)

STATE OF NEW YORK)
) S.S. #: _____ - _____ - _____
COUNTY OF _____)

_____, being duly sworn, deposes and says, under penalty of perjury:
(Name of Covered Member)

1. That I am the _____ of _____
(Relationship) (Name of Dependent Child)
2. That _____ is unmarried and _____ years of age.
(Name of Dependent Child)
3. That said individual resides with me in my home at _____
(Member's Complete Address)
4. That _____ became disabled prior to age 19 and continues as
(Name of Dependent Child)
such until this time, as evidenced by the attached medical report.
5. Please supply a copy of the letter from your **Basic Health Carrier** (i.e., GHI, HIP, Atena, etc.)
confirming your dependent's disability status and continued coverage to the Welfare Fund.
6. That due to his/her mental/physical handicap he/she cannot support his/herself.
7. That I make this affidavit to induce the United Federation of Teachers Welfare Fund ("Fund") to provide
its benefits to this dependent. I understand that the Fund is relying on my presentations herein and I
agree to indemnify and hold the Fund harmless in the event any of the information contained herein is not
true.
8. That I understand that I may be required to continue to provide proof of disability when requested by
the Fund.

DATED: _____, 200_____

(Signature of Covered Member)

Sworn to before me this
_____ day of _____, 200_____

(Notary Public)

