

ILWU-PMA Pension Plan  
ILWU-PMA Welfare Plan

ILWU-PMA Watchmen Pension Plan  
ILWU-PMA Supplemental Welfare Benefit Plan

October 17, 2008

To: ILWU Watchmen Local 75

From: Kate McClure, Executive Director

**Subject: Dependent Eligibility Verification**

At the direction of the Trustees, the Benefit Plans Office is conducting a dependent verification in accordance with collectively bargained dependent enrollment requirements.

All active and retired members and surviving spouses will be receiving their Dependent Verification packets during the month of October 2008. Members who do not have enrolled dependents will not receive a packet.

The packet (sample enclosed) includes a letter listing the dependent(s) the member has enrolled and a postage-paid envelope. The member is asked to indicate the dependent category applicable for each dependent and to provide the required documentation. It will not be necessary for respondents to furnish marriage and birth certificates if they have previously submitted these documents to the Plan Office; however, if the required documentation is not on file at the Plan Office or not received with the member's dependent verification response, it will be requested from the member. Certification forms for certain dependent children and same sex domestic partners are included in the packet. Supplies of the certification forms will be sent to the Locals when available and will also be available from the Plan Office. If any of the listed dependents do not continue to satisfy the definition for a qualified Dependent Spouse and/or Dependent Child, they should be listed in the space provided for deletions. The member is also asked to indicate each eligible dependent's payroll tax exemption status.

Non-respondents will be subject to having their dependent(s) deleted. Members may not add dependents on the Dependent Verification Form. Members who wish to add an eligible dependent should submit a Record Change Form, accompanied by the necessary documents, to the Plan Office.

Members are asked to respond as soon as possible, to prevent the need for a follow-up request and possible loss of dependent(s)' Welfare Plan eligibility.

Enclosures

A copy of this memo may be downloaded at [www.benefitplans.org](http://www.benefitplans.org)

# ILWU-PMA BENEFIT PLANS /

International Longshore & Warehouse Union —  
Pacific Maritime Association

[www.benefitplans.org](http://www.benefitplans.org)

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ILWU-PMA Pension Plan  
ILWU-PMA Welfare Plan

ILWU-PMA Watchmen Pension Plan  
ILWU-PMA Supplemental Welfare Benefit Plan

*Name*  
*Address*

October 2008

At the direction of the Trustees, we are providing you with the enclosed forms to verify eligibility of your dependents:

Dependent Verification Form - This includes a printout of the dependents you have enrolled, according to ILWU-PMA Welfare Plan records.

- 1) Please certify that the dependents listed meet the definition of a dependent under the Welfare Plan and follow instructions for required documentation. See the back of this page for definitions of eligible dependents.
- 2) If any of your listed dependents do not satisfy the definitions of an eligible dependent on the back of this page, delete them in the space provided on the form.
- 3) Sign and date the Dependent Verification form.

Important Notice Regarding Taxation – This includes a printout of the dependents you have enrolled according to Welfare Plan records.

- 1) Please review the information regarding taxation on dependent coverage.
- 2) Indicate if each of your enrolled dependents qualifies for taxation exemption and follow instructions for required documentation.
- 3) Sign and date the Notice.

A postage paid envelope is enclosed for your convenience in responding to this request. **Please respond within 20 days of this notice, to prevent the need for a follow-up request and possible loss of your dependent's Welfare Plan eligibility.**

If you have any questions, please contact the Benefit Plans office.

ENCLOSURES

## Plan Definitions of Eligible Dependents

**Definition of a Dependent Spouse:** A person who is married to a Longshoreman, Pensioner, or Social Security Retiree and who is so identified on the form provided by the Trustees for enrollment of dependents that has been most recently executed by such Longshoreman, Pensioner, or Social Security Retiree; provided, that the Trustees shall review the list of enrolled Dependent Spouses from time to time for the purpose of verifying Eligibility; and provided, further, that a marriage shall be deemed valid under the Plan if it is considered valid under the laws of the jurisdiction in which it was contracted. A same sex domestic partner of a Longshoreman, Pensioner, or Social Security Retiree and who is so identified on the form provided by the Trustees for enrollment of dependents that has been most recently executed by such Longshoreman, Pensioner, or Social Security Retiree, shall be deemed to be a Dependent Spouse provided the domestic partner and the Longshoreman, Pensioner, or Social Security Retiree (1) are not eligible to marry in their state of domicile; (2) are at least 18 years of age; (3) share a close personal relationship and are responsible for each other's common welfare; (4) are each other's sole domestic partner; (5) are not married and have not had another domestic partner enrolled in the Plan within the prior 12 months; (6) jointly share the same residence and are members of the same household, with the intent to continue doing so indefinitely; and (7) are not related by blood closer than would bar marriage.

**Definition of a Dependent Child:** A person who relies upon a Longshoreman, Pensioner, Social Security Retiree or Dependent Spouse for the majority of his or her support, such as food, clothing, housing, and medical care, and who is so identified on the form provided by the Trustees for the enrollment of dependents that has been most recently executed by the Active Employee, Pensioner or Social Security Retiree and filed with the Trustees, and is an unmarried person within one of the following classes, to wit: (a) a natural child of a Longshoreman, Pensioner, or Social Security Retiree, or (b) a legally adopted child of a Longshoreman, Pensioner, or Social Security Retiree, or (c) a stepchild or foster child of a Longshoreman, Pensioner, or Social Security Retiree, or (d) a child with whom a Longshoreman, Pensioner, or Social Security Retiree maintains a parent/child relationship if such child's natural parent is not in fact supporting such child, and in any one of the instances described in subparagraphs (a) through (d), who also either (i) has not attained 19 years of age or, if over 19, is recognized without additional cost to the Trustees as a dependent child under any plan utilized by the Trustees to provide Benefits, or (ii) has not attained 23 years of age but is a full-time student engaged in a course of study at a school recognized by the Trustees, or (iii) is, and continues to be, upon attaining the age limit set forth above, mentally or physically incapacitated so as to be incapable of self-sustaining employment; provided, that the Trustees shall review the list of enrolled Dependent Children from time to time for the purpose of verifying Eligibility.

DEPENDENT VERIFICATION FORM

Please check one of the boxes under relationship for your Dependent Spouse and provide required documentation.

DEPENDENT SPOUSE DOCUMENTATION - Legally married: marriage certificate (REQUIRED). If you have previously submitted a marriage certificate, you do not need to submit another copy. Same Sex Domestic Partner: (a) completed and notarized Same Sex Domestic Partner Certification Form (enclosed); (b) review "Important Notice on Taxation" on the back of this page.

Dependent Spouse: Date of birth: Relationship: \_\_\_\_\_

Legally Married       Same Sex Domestic Partner

Please check one of the boxes under relationship for each Dependent Child and provide required documentation.

DEPENDENT CHILD UNDER THE AGE OF 19 DOCUMENTATION - Natural and Step children: birth certificate; Legally adopted, foster children and legal guardianship: (a) a birth certificate or other proof of age, and (b) documentation establishing the child's placement for adoption, foster care or legal guardianship; Children of Same Sex Domestic Partner: birth certificate. (Parent must also qualify as a same sex domestic partner under the Plan). Any other child: (a) birth certificate or other proof of age; (b) completed and notarized "Dependent Certification Form" (enclosed). For all children between the ages of 19 and 23: documentation of student status supplied by school showing enrollment of at least 12 credits of coursework. For children covered under Group Health or Kaiser Oregon, documentation of student status is required for children between the ages of 21-23. Please review "Important Notice on Taxation" on the back of this page. If you have previously submitted copies of birth certificates or other legal documents to our office, you do not need to submit another copy.

Dependent Child: Date of birth: Relationship: \_\_\_\_\_

- Natural    Step    Legally Adopted    Guardianship/Foster    Other (specify) \_\_\_\_\_
- Natural    Step    Legally Adopted    Guardianship/Foster    Other (specify) \_\_\_\_\_
- Natural    Step    Legally Adopted    Guardianship/Foster    Other (specify) \_\_\_\_\_
- Natural    Step    Legally Adopted    Guardianship/Foster    Other (specify) \_\_\_\_\_
- Natural    Step    Legally Adopted    Guardianship/Foster    Other (specify) \_\_\_\_\_
- Natural    Step    Legally Adopted    Guardianship/Foster    Other (specify) \_\_\_\_\_
- Natural    Step    Legally Adopted    Guardianship/Foster    Other (specify) \_\_\_\_\_

*If any of the listed dependents do not satisfy the enclosed definitions for an eligible dependent, please use this space provided to delete them.*

<u>Name of dependent:</u>	<u>Current address</u>	<u>Reason for deletion</u>	<u>Effective date of deletion</u>

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.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT NOTICE REGARDING TAXATION**

***(This form does not apply to a legally married spouse. If your legally married dependent spouse is listed on this form, you do not need to provide a response on this page for that dependent.)***

If your otherwise eligible dependent child or same sex domestic partner does not qualify as a dependent under Section 152 of the Internal Revenue Code, the fair market value of the dependent coverage will be reported as taxable income and, if you are an active employee, income and payroll taxes on the fair market value of the dependent coverage will be withheld from your weekly paycheck. (For example, if you live in California, where the payroll tax rate is 16.1%, and if your income tax withholding is 15%, you will have a total of 31.1% of the fair market value of the dependent coverage withheld from your weekly paycheck.)

Participants are not required to pay payroll taxes on the value of dependent coverage for any dependent as long as the otherwise eligible dependent meets the following requirements:

For children who are your natural child, legally adopted child, step child, foster child or child under legal guardianship:

- (1) is a citizen, resident, or national of the United States;
- (2) resides with you for more than half the year (unless the parents are divorced and the non-custodial parent has a written agreement permitting him or her to claim the child as a dependent);
- (3) does not provide more than half of his or her own support;
- (4) is not claimed as a dependent by another taxpayer.

For children of a domestic partner or children who are NOT your natural child, legally adopted child, step child, foster child or child under legal guardianship:

- (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 claimed as a dependent by another taxpayer.

For same sex domestic partner:

- (1) is a citizen, resident, or national of the United States;
- (2) receives the majority of his or her annual support (food, clothing, housing, and medical care) from you; and
- (3) lives with you as a member of your household.

Please indicate by checking "Yes" which dependents currently on file meet the exemption criteria listed 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 as described above.

Dependent name:	Date of birth:	Yes	No
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**DOCUMENTATION REQUIRED:**

You will need to submit Worksheet 1, IRS Publication 501 (sample enclosed) for each dependent you marked "Yes" who is any of the following: (1) a same sex domestic partner, (2) a child that is your foster child, (3) a child that is under your legal guardianship, (4) a full-time student at least 19 and under 23, (5) dependent child that is permanently and totally disabled, (6) a same sex domestic partner's child, (7) any child for whom you submit a notarized Dependent Child Certification Form.

**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.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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. **Attach copy of birth certificate or other proof of age. 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.

\_\_\_\_\_  
Signature of Notary Public

My commission expires \_\_\_\_\_

[seal]

**SAME SEX DOMESTIC PARTNER CERTIFICATION FORM**

***This form must be notarized and returned to the Benefit Plans Office.***

Employee's name \_\_\_\_\_ Local/Reg No. \_\_\_\_\_

Partner's Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

I confirm that the above named individual is my Same Sex Domestic Partner and that:

- 1) he or she is at least 18 years of age;
- 2) he or she shares a close personal relationship with me and we are responsible for each other's common welfare;
- 3) we are each other's sole domestic partner;
- 4) I am not married and have not had another domestic partner enrolled in the Plan within the prior 12 months;
- 5) we jointly share the same residence and are members of the same household, with the intent to continue doing so indefinitely; and
- 6) we are not related by blood closer than would bar marriage.

Provide a copy of at least two of the following as verification of the same sex domestic partner's common residency (dated to confirm eligibility at the time of enrollment): (i) driver's license, (ii) proof of auto insurance, (iii) State Identification Card, (iv) utility bill, or (v) voter registration.

**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.

\_\_\_\_\_  
Signature of Notary Public

My commission expires \_\_\_\_\_

[seal]



**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 . . . . . **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 Kidnapped child under Qualifying Relative.*

Employee name: \_\_\_\_\_ Local / Reg No. \_\_\_\_\_

Dependent name: \_\_\_\_\_ Date of birth \_\_\_\_\_  
mm/dd/yyyy