TEAMSTERS CALIFORNIA STATE COUNCIL
OF CANNERY AND FOOD PROCESSING UNIONS

CALIFORNIA PROCESSORS
INCORPORATED

JOINT BENEFIT TRUST

ADMINISTRATOR
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CHAIRMAN, John Hurley
CO-CHAIRMAN, John Hailstone

REQUEST FOR CONTINUATION OF COVERAGE OF MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

PART I—EMPLOYEE'S (MEMBER'S) STATEMENT

Name of Employee (Member)	Employee's S.S.#
Address	Phone Number
Name of Dependent Child	Child's Birth Date

Child's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Is child dependent upon you for support? ☐ No ☐ Yes. If "Yes" what percentage of support do you contribute: Yourself ☐ % Government Funding ☐ % Other ☐ %

Is child a full-time student? ☐ No ☐ Yes. If "Yes" give school name and location:

Has child been employed full-time since reaching limiting age (19) for dependent? ☐ No ☐ Yes
If "Yes, give name(s) and address(es) of employer(s) and dates employed:

Summary of any institutional care:

Name of Institution	Date	Nature of Care

Employee's Signature	Date

PART II—ATTENDING PHYSICIAN'S STATEMENT

Is child now incapable of self-sustaining employment because of mental or physical handicap?
☐ No ☐ Yes

Did such incapacity exist prior to child's attaining age 19? ☐ No ☐ Yes
If "No" when did incapacity first exist?

May child be employable in future? ☐ No ☐ Yes ☐ Questionable

Nature and Cause of Incapacity:

Date of Onset:	Prognosis:

Name of Physician	Degree	Phone Number	Date

Address	Physician's Signature

IF AN EMPLOYEE OR MEMBER HAS A MENTALLY OR PHYSICALLY HANDICAPPED CHILD WHO, UNDER THE TERMS OF THE PLAN, QUALIFIES FOR THE CONTINUATION OF COVERAGE AFTER THE PLAN LIMITING AGE, THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE ADMINISTRATIVE OFFICE WITHIN 31 DAYS FOLLOWING THE ATTAINMENT OF THE LIMITING AGE.