MEBA Medical & Benefits Plan
1007 Eastern Avenue
Baltimore, Maryland 21202-4345
(410) 547-9111

Dependent Parent Supporting Statement

This form must be completed by the participant, and include a copy of your tax returns from the preceding year. If tax returns are self-prepared, you must include a certified copy of your tax returns. All questions are to be answered. Participant's and dependent's name should be printed. Both **parent** and **participant** must sign this form.

Date: ___________________________________

Participant's Name: ______________________ Social Security #:____________________

Full Name of Dependent Parent: ____

Relationship: ________________________

Dependent Parent Resides with: _____________________ Relationship: _______________

Address of Dependent Parent: ____
City, State and ZIP Code: ____

Does this Dependent Parent contribute money to the household for room, board or other expenses? No: Yes: If yes, How much? $_______________.
Is money contributed from parents own funds? No: Yes:
If no, from whose fund? _______________________________.

Have you claimed this dependent parent on your Federal Income Tax Returns?
No: Yes: If Yes, latest year claimed: ________________ (Please note: If taxes are self-prepared, attached certified copy of tax returns)

Enter the amount you spent for the support of this dependent parent during the last 12 months prior to the date of this application $ __________________________________.
(Amounts spent for support should include items as the cost of board, lodging, clothing, medical and dental care, and similar items. If dependent lives in your home, exclude cost of board and lodging).

(Continued)

Enter the amount that this dependent has spent towards their own means for own support. $________________.
If this dependent receives Social Security, Pension or other assistance, please list below.

Name	Address	Monthly Amount

Enter the amount of dependent's earnings: $ ______________________________________
(Include all wages, interest, profits, rents, etc.)

Did any other person contribute to dependent's support? No: Yes:
Name: ____
Relationship to dependent: __________________________
Address: ____
City: ____
State and Zip Code: _______________________________

Declaration of Dependent

I represent that the above information has been examined by me and it is true, correct and complete to the best of my knowledge, and I ask the MEBA Medical and Benefits Plan to act on my representation.

___________________________________ ________________________________
Signature of Dependent Date

Declaration of Participant

I represent that the above information has been examined by me and it is true, correct and complete to the best of my knowledge, and I ask that MEBA Medical and Benefits Plan to act on my representation.

___________________________________ ________________________________
Signature of Participant Date