



INSURED NAME _____ DEPENDENT _____

TRUST FUND _____ RELATIONSHIP _____

EMPLOYER _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ LOCAL UNION _____

RE: STUDENT STATUS

Coverage for dependent children ceases on their 19th birthday, unless they are full-time (12 units) students of an accredited educational institution, unmarried, and rely upon the insured for support.

If your dependent qualifies, please obtain a letter each and every semester/quarter on school letterhead, including all the information requested below, bearing the registrar's signature and the school's embossed seal; or have the school complete this form with the embossed seal.

NOTE: Verification must be dated after the quarter/semester begins and the student is actively attending classes.

This is to certify that _____ is a

full-time part-time student at _____
(School Name)

(Street Address) (City, State, Zip) (Telephone Number)

which is a _____, taking _____ units for the

quarter semester, beginning _____ and ending _____

BY _____ DATE _____ TITLE _____

NOTE: THIS FORM IS NOT VALID WITHOUT EMBOSSED SCHOOL SEAL. INCOMPLETE INFORMATION WILL CAUSE DELAY IN YOUR CHILD'S ELIGIBILITY FOR BENEFITS.

RETURN COMPLETED FORM TO THE APPROPRIATE ADDRESS BELOW

ALHAMBRA: P O BOX 1121 ● BENEFIT INFORMATION CENTER ● ALHAMBRA, CA 91802-1121
SAN DIEGO: 4666 MISSION GORGE PLACE #1 ● SAN DIEGO, CA 92120
LAS VEGAS: P O BOX 26509 ● LAS VEGAS, NV 89126-6509