



**CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE AND PENSION FUNDS**

STUDENT VERIFICATION FORM
For Full Time Students (Age 19-23)

- Accident and Health Benefits are granted for Full Time Students (excluding Life Insurance, Dental and Vision Benefits) provided student is not married and/or student does not work for longer than 4 months. A student working full time longer than 4 months will lose coverage at the end of the fourth month of work.
- Updates are granted through summer and again through end of the year. Official notification from the school is required for each period.
- Summer coverage is provided if full-time status is maintained in consecutive school periods.
- Certain schools on Quarter System or certain Trade Schools may be updated for shorter periods.
- The Fund must be notified if student changes from Full Time Status.
- Overpayments will be applied to account if status changes and the Fund is not notified.

MEMBER MUST COMPLETE:	
1.	MEMBER'S IDENTIFICATION NUMBER: _____ MEMBER'S NAME: _____ STUDENT'S NAME: _____ DATE OF BIRTH: _____ STUDENT'S ID: _____
2.	This will serve Central States, Southeast and Southwest Areas Health and Welfare Fund as notice and verification that my dependent, _____ is fully dependent on me for support and is a full-time student at _____.
3.	Please indicate if student attended school full time for previous term: <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	_____
	_____ Date _____ Signature of Member

SCHOOL REPRESENTATIVE MUST COMPLETE:	
1.	This will serve as verification that _____ is/was a full-time student attending this institution (give current full time dates only):
2.	FROM: _____ TO: _____ SCHOOL: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ PHONE: () _____ EXTENSION: _____
3.	_____ / / Signed _____ Title _____ Date

SCHOOL STAMP OR SEAL:	
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THIS FORM MUST BE RETURNED WITH ANY OTHER STUDENT DOCUMENTATION.