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.
- Summer coverage is provided if full-time status is maintained in consecutive school periods. Updates are granted through summer and again through end of the year. Official notification from the school is required for each period.
- 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 your account if status changes and the Fund is not notified.

MEMBER MUST COMPLETE:

1. MEMBER'S IDENTIFICATION NUMBER: **806** _____
   MEMBER'S NAME: _____
   STUDENT'S NAME: _____ DATE OF BIRTH: _____
   STUDENT'S SCHOOL 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: ☐ Yes ☐ No
4. _____ _____
   Signature of Member Date

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. _____ _____ _____
   Signature of School Representative Title Date

SCHOOL STAMP OR SEAL:

THIS FORM MUST BE RETURNED WITH ANY OTHER STUDENT DOCUMENTATION.

PO Box 5112
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Print Form

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